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Montana Health
Care Authority
Statewide
universal health
care access plans

Statewide Universal Health Care Access Plans

Volume V

Health Insurer
Cost Management Plans

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**State of Montana
Health Care Authority
Report to the Legislature
October 1, 1994**

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INTRODUCTION

Volume V of the *Statewide Universal Health Care Access Plans* report includes an examination of Health Insurer Cost Management Plans which summarizes health insurer data and provides specific cost management strategies utilized by insurers authorized to do business in Montana. Senate Bill 285 directed the Authority to complete this compilation as part of its responsibilities related to health care cost containment. Recommendations relative to the use of this information are also provided in this report.

The collection and compilation of Health Insurer Cost Management Plans was completed and assembled by Authority staff, with preliminary work completed through a consulting contract with Steve Yeakel.

Statewide Universal Health Care Access Plans

Volume V
Health Insurer
Cost Management Plans

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CONTENTS

Introduction	
Contents.....	iii
Summary Report.....	1
Purpose of Cost Management Reporting.....	1
Reporting Procedure.....	2
Health Insurer Data.....	2
Data and Demographic Reporting Issues.....	4
Cost Management Plans.....	6
Recommendations.....	6
Health Insurer Cost Management Survey.....	Attachment A
Health Insurer Cost Management Plans:.....	Attachment B

AMERICAN CHAMBERS LIFE INSURANCE COMPANY

AMERICAN NATIONAL INSURANCE COMPANY

BLUE CROSS/BLUE SHIELD OF MONTANA

CIGNA HEALTHCARE

CONTINENTAL LIFE & ACCIDENT COMPANY

(INCLUDES NATIONAL GROUP LIFE)

EMPLOYERS HEALTH INSURANCE COMPANY

FORTIS BENEFITS INSURANCE COMPANY

GENERAL AMERICAN LIFE INSURANCE COMPANY

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

HOME LIFE FINANCIAL ASSURANCE COMPANY

HORACE MANN

JOHN ALDEN LIFE INSURANCE COMPANY

JOHN DEERE INSURANCE COMPANY

LIFE & HEALTH COMPANY OF AMERICA

METROPOLITAN LIFE INSURANCE COMPANY

MUTUAL OF OMAHA INSURANCE COMPANY

CONTENTS (CONTINUED)

NATIONAL HEALTH INSURANCE COMPANY
NEW YORK LIFE INSURANCE COMPANY
NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY
PRINCIPAL MUTUAL LIFE INSURANCE COMPANY
PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
STATE FARM INSURANCE COMPANY
TIME INSURANCE COMPANY
TRANSPORT LIFE INSURANCE COMPANY
TRUSTMARK INSURANCE COMPANY
UNION LABOR LIFE INSURANCE COMPANY
UNIVERSE LIFE INSURANCE COMPANY
WASHINGTON NATIONAL INSURANCE COMPANY
WESTERN FARM BUREAU LIFE INSURANCE COMPANY
WESTERN MUTUAL INSURANCE COMPANY
WORLD INSURANCE COMPANY

SUMMARY REPORT

Purpose of Cost Management Reporting

Senate Bill 285, as codified in 50-4-503 Montana Codes Annotated, required that health insurers prepare cost management plans with consideration of integrated systems for health care delivery. The statute recommends that the Health Care Authority consider the submitted plans in its development of a unified health care budget. Standards and procedures for the submission of the plans were developed by the Authority, with the only statutory guidance being an exemption of the reporting requirements relative to dental insurance. The procedures for the reporting requirements are detailed in Attachment A.

The cost management plans have five general purposes. First, through the passage of SB 285 during its 1993 session, the legislature agreed that cost management strategies would encourage innovation and health care cost savings in the insurance industry. Second, the development of plans was also viewed as promoting continuous quality improvement while inspiring cost controls in the health care industry. Third, the requirement to address integration of health care delivery in SB 285 recognized recent insurer trends to maximize utilization review functions while trying to sensibly respond to constant changes in the delivery of health care. Fourth, information which can be provided by health care insurers should enhance cost containment strategies at policy making levels. Fifth, information from cost management plans can increase the level of consumer, employer, or other types of purchasers' awareness of activities which are truly intended to help slow the growth of health care costs.

This report provides a brief summary of data received from health insurers authorized to conduct business in Montana, issues which appeared during the collection and analysis of the data, and copies of actual cost management plans submitted to the Authority. Many of the insurers also submitted supplementary information. Copies of specific supplemental information are available upon request.

Reporting Procedure

In January 1994, a list of 494 insurers licensed to conduct business in Montana was provided to the Authority by the Insurance Commissioner's Office (ICO). A copy of Attachment A was sent to each, asking that two general areas of health insurance market information be completed: cost management strategies used to assist the companies in controlling health care costs which they pay through approved claims; and, specific data for calendar year 1992, such as numbers of lives covered, small and large group certificates issued, total premium revenues, total administrative costs, and total health care costs reimbursed.

The reporting requirements applied specifically to major medical and catastrophic health insurance coverage. Supplemental insurance products were exempted from having to be reported, although a number of insurers supplied the Authority with supplemental coverage information.

Out of 252 total respondents, 52 submitted financial and demographic data indicating some level of health care insurance business conducted in the state. Thirty-two of the 252 respondents returned cost management plans. There were a few cost management reports returned by insurers who were not actively marketing comprehensive or major medical products in 1992, but were willing to participate in the study.

Health Insurer Data

Of the 252 responses, 52 insurers reported varying levels of health insurance business in the state. Forty-nine of the 52 insurers reported a total of 315,797 covered lives. The 52 insurers reported premium earnings of \$286,927,077 for calendar year 1992. Table 1 provides a comparison of data reported to the Authority to data reported to the Insurance Commissioner for 1992. The top twenty insurers, in terms of premiums earned, reporting in the small group market indicate numerous differences with their major medical and comprehensive product lines for all groups.

TABLE 1

	1992 Premiums Earned as Reported to Insurance Commissioner - Small Market Only	1992 Premiums Earned (& Lives Covered) as Reported to MHCA - Major Medical & Comprehensive Coverage - All Markets
Blue Cross/Blue Shield	\$31,025,981	\$212,952,723 (200,211)
John Alden Life Ins Co	4,021,232	8,621,761 (7261)
Principal Mutual Life Ins Co	2,424,043	13,157,093 (8169)
Travelers	1,769,162	5,874,864 (18,269)
Continental Life & Accident	920,243	515,766 (891)
Western Mutual Ins Co	650,664	828,767 (1983)
CUNA Mutual Ins Society	610,898	768,790 (522)
John Deere Ins Co	525,868	525,868 (236)
Central Reserve Life Ins Co	438,115	310,188 (408)
Life Investors Ins Co of America	430,397	did not report
Time Ins Co	403,526	1,736,777 (2893)
Nationwide Life Ins Co	377,399	inadequate information
State Farm Mutual Automobile Ins Co	359,133	5,296,584 (5955)
Fortis Benefits Ins Co	305,455	555,686 (435)
United Of Omaha Life Ins Co	199,521	3,155,485 (22,741)
General American Life Ins Co	181,240	inadequate information
State Mutual Life Assurance Co	170,253	170,253 (12)
New York Life Ins Co	150,000	inadequate information
Lincoln Mutual Life & Casualty Ins	111,547	565,775 (474)
Mutual Service Life Ins Co	108,496	claimed exemption

Data and Demographic Reporting Issues

There are a variety of reporting factors which suggest that the data and demographic information be examined with caution.

- Disparities among the returned cost management data information appears to have resulted in wide variations in ratios between premiums earned and lives covered. Possible contributions to these variations may have come from reporting where some insurers are able to include actual numbers of dependents, others who are only able to report number of individuals/employees covered under each group certificate, and still others who may be reporting total numbers of covered lives by using an industry-accepted multiplier times the number of individuals/employees covered under each group certificate. Judging by the types of questions from many insurers, substantial misunderstandings existed on how the information was to be reported.
- A few respondents claimed that, because of inadequacies in their current tracking systems, they were unable to accurately provide the requested information, so submitted estimates or data resulting from multipliers. The multipliers used, based primarily on telephone conversations with insurers, were 1.5 contracts per group certificate issued or 1.7 lives per contract issued.
- A few insurers appeared to have mixed products designed as supplemental benefits or other benefits specifically exempted from the cost management reporting with health benefits which were to be reported.
- Through this process, there was no method available to cross-reference individuals covered under more than one plan, so the aggregated covered lives potentially include duplicated numbers. Specific examples would include couples covered under separate plans though different employment policies.

- It appeared, in a few instances, where certificates issued were possibly reported as the same as covered lives. This example would be expected for insurers who only reported their product was issued as individual policies where there were no dependents under each certificate issued. The likelihood of this type of scenario occurring is assumed to be minimal.
- Some of the insurers reported information outside of calendar year 1992. For purposes of this report, if it was usable, the information was applied as if it were 1992 data.

Along with other activities of the Authority, this effort demonstrated the need for the state to strengthen and coordinate its data gathering and analysis capabilities. The data collected does not appear to validate other efforts at gathering information relative costs of health care coverage. Besides currently having minimal data collection capabilities, the Authority's major hinderance to acquiring accurate data is the inability to require self-insurance funds to report because of provisions in the federal Employee Retirement and Income Security Act (ERISA) of 1974. With few exceptions, entities who are exempted from state oversight through the Insurance Commissioner's Office either were not on the list of insurers originally provided by the ICO to the Authority or did not respond if they were on the list. Therefore, few of the self-insurance funds were located as a part of this study effort.

Similarly, it is speculated that some health care insurers who are actively marketing health products in Montana may have ignored the request for cost management strategies. The Authority has the statutory ability to collect this type of information in its directive from the legislature to develop and implement a unified health care data base (50-4-502 MCA). However, a requirements analysis for the unified health care data base must first be completed before rules in this area are promulgated. Further, if rules were to be adopted which required mandatory cost management and data reporting, the Authority's ability to enforce such requirements across state boundaries may prove legally troublesome.

While the process of surveying health care insurers experienced some difficulties, those who

ATTACHMENT A

HEALTH INSURER COST MANAGEMENT SURVEY

ATTACHMENT A

**HEALTH INSURER
COST MANAGEMENT PLANS**

Montana Health Care Authority

November 10, 1993

INTRODUCTION

This document presents guidelines for the development of insurer cost management plans required as part of the State of Montana's health care reform initiative. Senate Bill 285, Section 20 states that,

- (1) (a) "Except as provided in subsection (3), each health insurer shall:
 - (i) prepare a cost management plan that includes integrated systems for health care delivery; and
 - (ii) file the plan with the authority no later than January 1, 1994.
- (b) The authority may use plans filed under this section in the development of the unified health care budget.
- (2) The plans required by this section shall be developed in accordance with standards and procedures established by the authority.
- (3) The provisions of this section do not apply to dental insurance."

The Authority is therefore requiring that insurers supply two types of information:

- 1) a narrative description, prioritized and Montana-specific, of the insurer's programs and policies which address cost management, and
- 2) a packet of one-page data sheets which allow a statistical look at the insurer's health-specific Montana policies.

The Authority supports the movement toward cost management approaches that reduce administrative time and cost associated with traditional utilization review methods, promote significant participation by providers and facilitate learning among providers. While work in these directions goes forward, there continues to be near term needs for balance between cost containment methods that focus on general patterns of care and those that focus on the review of individual cases and practitioner's behaviors.

The data supplied by insurers and collected by the Montana Health Care Authority will be useful in accomplishing the overall responsibilities of the Authority. Among its many charges, the Authority is to create several planning documents and cost containment plans. Among them are

- a unified health care budget,
- actuarially sound cost estimates,
- health care resource management plans, and
- annual cost containment targets.

In addition, the Authority must create a "unified health care data base." The information collected from Montana insurers will compliment the information in the data base, and be of assistance in completing the tasks mentioned above in a comprehensive, satisfactory manner.

The filing of Montana market cost management plans by health insurers will represent a significant early step in building a reliable base of information for the Authority's decision-making process as it potentially reshapes the roles of the insurance industry and the other major components of Montana's health care system.

PURPOSES OF COST MANAGEMENT PLANS

Guidelines for Insurer Cost Management Plans are being issued to insurers who provide coverage for a significant number of residents in the individual, small group and large group markets in the state of Montana. The purposes of these guidelines are to:

- * encourage innovation and improvement by insurers in their creation and implementation of cost management strategies
- * facilitate approaches that integrate continuous quality improvement with cost containment
- * foster initiatives by insurers that promote the development of integrated systems of health care delivery
- * produce information that will assist the Health Care Authority in developing the global budget, plans for universal access, and the unified health care data base required by SB 285, and
- * provide information to consumers and employers by making copies of insurer's cost management plans publicly available and on file at the Health Care Authority office.

COST MANAGEMENT PLAN NARRATIVE

The Health Care Authority is interested in acquiring and analyzing information regarding cost management strategies used by insurers. In order to collect such information from insurers in a format that permits meaningful analysis and promotes comparability, seven specific cost management areas have been identified as being particularly relevant to the purposes and goals of Senate Bill 285. These areas are described briefly below:

AREA ONE: Integrated Systems for Health Care Delivery - Senate Bill 285 states that, "Each health insurer shall prepare a cost management plan which includes integrated systems for health care delivery ..." An "integrated system for health care delivery" has been defined as,

"an organized private or public, proprietary or nonprofit delivery system for a continuum of health care services. The system may include the following elements:

- a) Care that is coordinated through a primary care manager chosen by the patient from a network of providers.
- b) Continuous quality improvement processes to ensure quality of care, patient satisfaction and efficiency.
- c) Financing methods that provide incentives for health care providers and patients which encourage quality care, efficiency, successful outcomes and appropriate use of health care services."

This requirement of the legislation encourages insurers to propose benefit plans combining preventive and treatment services that promote cost-effective care. Of particular interest is the extent to which insurers are taking advantage of integrated financing and delivery systems.

AREA TWO: Quality Improvement and Assessment - Continuous quality improvement programs can lead to long-term increases in the cost effectiveness of health care. Contracting with providers who are able to document a continuous quality improvement process is a first step.

AREA THREE: Utilization Management - Certain utilization management techniques have been demonstrated to be cost-effective in the review of both medical/surgical and mental health/chemical dependency treatment. Insurers typically

generate measures of utilization management outcomes, patient satisfaction and aggregate costs and savings.

AREA FOUR: Alternative Payment Mechanisms to Providers - Payment strategies that promote cost-effective use of services in all types of treatment settings are desired. In particular, insurers are moving away from charge-based payment systems and adopting reimbursement mechanisms that foster cost containment.

AREA FIVE: Third Party Liability/Coordination of Benefits - It is important to take aggressive action to identify and utilize all potential sources of payment from liable third parties. Insurers should pursue other liable third parties, as well as coordination of benefits and calculations of savings to cost ratios, in their cost management plans.

AREA SIX: Administrative Methods - Cost-effective administrative techniques are designed to achieve both claims processing and management efficiencies. It is important that insurers address cost effectiveness and continuous improvements in their own administrative processes and structures. Methods include standardized procedures for claims submission, as well as elements needed for a unified database; common patient and provider identifiers; common procedure coding; edits to ensure accuracy of the data collected for processing and eventually for tracking patient health status and outcome; and the promotion of the use of standardized medical records and common claims forms.

AREA SEVEN: Anti-Fraud Efforts - Fraud and abuse prevention, detection and recovery procedures can be powerful cost-savings tools. Efforts to prevent and detect fraud and abuse, and the pursuit of providers and patients who commit fraud are of interest here.

PREPARATION OF COST MANAGEMENT PLANS

The process of preparing cost management plans is intended to facilitate the assessment of existing methods that lead to better integration of quality improvement and cost control. To provide an outline that may assist in the preparation and review of these plans, the guidelines present specific examples of existing approaches to cost management that currently are used by insurers. This list is not intended to be all inclusive. The Authority also recognizes that rapid developments are taking place in quality improvement and cost containment methods. Therefore, insurers' responses to the guidelines should address uses of new methods as well as applications of existing methods.

Insurers should highlight the key strategies they employ in each of the seven areas and organize them in priority order of their

contribution to the insurer's overall plans and objectives. For example, an insurer may first want to discuss point number thirty-nine, "fraud and abuse controls," and then discuss point number five, "cost-effective provider networks," because of the priority of those programs/policies within the company.

Insurers may include reports and other documentation that support the description of the policies and procedures in place. But preparers are asked to respond using the same identifying system of letters and numbers as used in these guidelines. Written responses in each of the areas should be kept as brief as possible.

Insurers are also asked to focus on the policies and procedures which have been implemented by their company in Montana, and so specify, while mention of the policies and procedures employed in markets outside of Montana would also be appropriate.

If an insurer currently does not use in Montana a particular cost management method listed in the guidelines, but plans to do so in the future, the insurer is asked to specify the main features and time table for an implementation program.

If a particular cost management method mentioned in these guidelines is judged to be ineffective or incompatible with the insurer's overall quality improvement and cost management strategy, the insurer is asked to describe the reasons for this judgment.

As noted above, one purpose of the planning process is to encourage insurers to innovate and improve their cost management practices. If there are methods not listed in the guidance document which the insurer has found to be particularly valuable, the insurer is asked to define them and describe the experiences with the approach. This would include methods that connect and combine the traditional areas described here.

Finally, we are requesting that insurers provide "hard data" regarding covered lives, premiums written, administrative costs and direct claims incurred. A data sheet and more specific information is found at the end of these guidelines for the development of cost management plans.

Questions regarding the completion of cost management plans may be directed to Steve Yeakel, project consultant, or Sam Hubbard, Executive Director, Montana Health Care Authority. Both persons can be reached at 406/443-3390 (406/443-3417, FAX).

Please complete and return insurer cost management plans January 1, 1994, to

Health Insurer Cost Management Plans
Montana Health Care Authority
Capitol Station
Helena, MT 59620

COST MANAGEMENT PLANS

Topic/Area One: Integrated Systems for Health Care Delivery Strategies: Insurers' cost management strategies related to developing integrated systems for health care delivery may include:

1. Benefits packages that promote coordinated care, through, for example:
 - An identified point of entry into the system
 - Selection, by patients, of a primary care provider
 - The delivery of preventive services to reduce or prevent disease, injury or disability
2. Benefits packages that include health promotion and promote health education, for example:
 - Discounts to encourage healthy lifestyles (e.g. no smoking)
 - Educational materials for members concerning healthy lifestyles and high-risk conditions
3. Flexible benefit plans that provide the most cost-effective services that meet a patient's needs. These plans could:
 - Offer point of service selection of benefits
 - Encourage use of home-based care
 - Discourage institutionalization
 - Promote use of outpatient settings, including intensive outpatient treatment modalities, for mental health/substance abuse treatment
 - Provide coverage for most appropriate level of care (for example, skilled nursing care in a nursing facility or provided by a home health agency in lieu of inpatient hospital care)
4. Provider networks that have been developed based on utilization, quality profiling, and patient satisfaction:
 - Comparison of provider practice patterns based on cost, service use, and quality by using statistical methods
 - Identification of participating providers
 - Feedback mechanism to providers for educational purposes and to alter practice patterns
 - Integration of inpatient services with community health and other ambulatory services
5. Provider networks that promote cost-effectiveness, including:
 - Identification of low cost providers and contracts with them for specific services (for example, bulk purchasing through competitive arrangements for durable medical equipment, medical supplies, prescription drugs, and other services)
 - Use of primary care providers other than physicians to provide primary care in collaboration with physicians within the limits of existing licensure requirements
 - Use of allied health professionals where appropriate

- Use of in-state providers where appropriate and cost-effective

6. Other innovative strategies for integrated health care delivery systems that address access, cost containment, reduction of administrative burden, and continuous quality improvement.

Topic/Area Two: Quality Improvement and Assessment

Strategies: Insurers' cost management plans may include the following quality assurance strategies:

7. Contracting with providers with quality improvement and assessment processes in place, in their treatment settings, that reflect certain critical components

- Continuity of care
- Coordination of care
- Mechanisms for minimizing patient risk
- Continuous quality improvement processes to ensure quality of care, patient satisfaction, and efficiency

8. Collection of data on efficiency, quality and patient demographics and health status to support evaluative functions and outcomes research. For example,

- Patient functional outcomes can be tracked through the collection of clinically-specific information. Thus, an organization's performance can be tracked to "flag" those providers that deliver high quality care and those that need improvement.
- Practice guidelines can be incorporated into the medical review criteria of provider organizations to monitor appropriateness and outcomes of care.

9. Use of provider profiling results in development of quality improvement and assessment features, such as:

- Use of provider profiling to measure:
 - Access
 - Outcomes
 - Treatments (medications, surgeries)
 - Diagnoses
- Use of process measures to determine:
 - Compliance with standards for care of chronic conditions, preventive services, screening
 - Whether the number of tests, procedures, or referrals occurred during a given time period
- Use of outcome measures to assess:
 - Mortality
 - Complications
 - Health status
 - Re-admissions

10. Other innovative strategies in quality improvement and assessments including collaborative relationships among insurers and other organizations that bring complementary skills and

experiences to bear in quality improvement and assessment activities.

Topic/Area Three: Utilization Management

Strategies: Insurers' cost management plans may include the following utilization management strategies:

11. Provider profiling to determine utilization trends and service delivery patterns. Provider profiling may include:

- Collection, analysis and interpretation of provider practice data using statistical methods and small area analysis
- Establishment of specific standards for provider performance; providers who meet the profiling performance standard may be exempt from further review, thereby reducing the need for case-by-case review. High and low cases could be identified for more detailed review, and consideration should be given for special situations, including limited access to providers in rural areas.

12. Case Management to ensure appropriate utilization of health care resources in the treatment and management of catastrophic, chronic and complex diseases. Case management may include:

- Case management for catastrophic illness and injuries
- Management of treatment and care for patients with chronic conditions
- Case management for complex diseases and procedures with programs designed for treatment to occur in the most appropriate setting (e.g. outpatient departments, home) and with the most appropriate service (e.g., home health, nursing home)
- Assessment of the case management process to determine that patients progress, meet treatment goals, and are not being over- and under-served
- Development of patient/provider appeals process for adverse decisions resulting from the discharge planning process

13. Pre-admission and admission review to determine appropriateness of admissions. Pre-admission and admission review may include:

- Focused review of conditions and treatments that are known to have higher rates of variation and inappropriateness
- Review of elective admissions prior to hospitalization, for example, elective C-sections
- Pre-screening of selected procedures to be performed in either inpatient or outpatient settings
- Admission review of pre-certified elective admissions within 48 hours
- Review of emergency and non-routine maternity admissions within one working day of admission

- Patient/provider appeals process for adverse decisions resulting from pre-admission or admission review process

14. Concurrent Review and/or On-site Review to determine the appropriateness of continued stay. Concurrent review and/or on-site review may include:

- Focused review of conditions and treatments that are known to have higher rates of variation and inappropriateness
- Follow-up of information obtained during the pre-admission review to determine appropriateness of review decisions
- Patient/Provider appeals process for adverse decisions resulting from the concurrent and/or on-site review process
- Analysis of treatment plan performed at periodic intervals
- Concurrent review of cases that extend beyond the originally assigned length of stay, or the length of stay for the assigned severity of illness or intensity of service required
- Concurrent review, not including routine maternity admissions, for a specific number of hospital stays

15. Discharge Planning to determine the appropriateness of discharge. Discharge planning may include:

- Assessment of patient needs in order to arrange for the necessary services and resources to affect appropriate and timely discharge and positive patient outcome
- Assessment of patients with special needs and resource-intensive diagnoses (for example, traumatic brain injury, spinal cord injury, psychiatric disorders) referred to out-of-state facilities for care to affect appropriate and timely return to in-state care
- Development of patient/provider appeals process for adverse decisions resulting from the discharge planning process

16. Outpatient Utilization Review to determine the appropriateness of treatment and/or procedure in outpatient settings. Outpatient utilization review may include:

- Pre-certification of outpatient treatments and procedures that are expensive and/or likely to be used inappropriately
- Pre-certification of outpatient surgeries that are frequently performed (for example, tonsillectomy and adenoidectomy, myringotomy)
- Review of utilization of emergency room services to determine appropriateness of setting

- Patient/provider appeals process for adverse decisions resulting from outpatient utilization review
17. Pre- and Post-Payment Claims Review
- Pre-payment review
 - Validate that hospital, physician and outpatient services claims are not in conflict with or exceeding pre-defined limits compared to claims previously adjudicated
 - Suspension or rejection of claims
 - Post-payment claims review
 - Providers identified for review by referral, practice profiling or rebundling software
 - Contractual obligations of providers to refund payments if requested
18. Internal Retrospective Review to determine the accuracy of the decisions made by physicians, nurses, and utilization review coordinators. Internal retrospective review may include:
- Secondary review of reviewer decisions
 - Audit of randomly sampled cases for accuracy and consistency of reviewers' judgments
 - Performed in-house or by third party
19. Drug Utilization Review to determine the accuracy and appropriateness of prescription medications. Drug utilization review features may include:
- Prospective Review - requires on-line information and is based upon pharmacist/prescriber and pharmacist/patient interaction
- Assessment that medication and dosage are appropriate for diagnosed condition
 - Assessment of potentially harmful drug interactions with other drugs and follow-up with physician contact
 - Assistance to patients with information, compliance and identification and resolution of problems
 - Use of a formulary (defined as "a set of guidelines established and agreed to by providers and pharmacists that determines which prescriptions can be replaced by other drugs whose effectiveness is similar and whose cost is lower")
- Retrospective Review based upon analysis of utilization patterns
- Focus for appropriate (over- and under-) utilization can be a drug, prescriber, patient or pharmacy
 - Education for provider and patient regarding generic substitution

- Review of "dispense as written" indications on prescriptions
- Fraud and abuse controls
- Compliance/noncompliance of patient with instructions, and of prescriber and pharmacy with formulary
- Patient/provider appeals process for adverse decisions resulting from the drug utilization review process

20. Utilization Management Tracking to determine if utilization management strategies are effective and should be continued and/or modified. Tracking may include:

- Collection, analysis and interpretation of health care statistical data to determine effectiveness of cost management measures, to design benefits and to better manage care
 - Compare all hospital utilization rates
 - Examine provider practice and referral patterns
 - Compare claims data to norms
 - Analyze monthly utilization
 - Conduct health risk appraisals
 - Assess quality of care
- Processes to measure ongoing effectiveness of utilization review programs and eliminate ineffective procedures

For hospitals: for example, cost per review, average cost per hospital stay, average length of stay, percent of hospital days determined inappropriate based on a sample of medical records, estimate of percent of hospital inefficiency

For providers: for example, cost of review, number of services denied or reduced

- In the aggregate: for example, cost-effective substitution of services, advantages of alternative benefit programs, overall insurer savings
- Processes to disseminate findings from utilization management efforts and to use findings to restructure benefits and refine further utilization management techniques
- Tracking of utilization review outcome data annually for effectiveness
 - Number of reviews
 - Percent cases referred for physician review, appealed, overturned
 - Average length of stay (ALOS) in days
 - Change in ALOS from year to year
 - Admissions/1000
 - Outpatient procedures/1000
- Tracking of mental health/chemical dependency utilization
 - Number of days/1000
 - Average adult, adolescent inpatient lengths of

stay (days)

- Average number adult, adolescent outpatient psychotherapy visits per patient
- Reporting cost and utilization experience, savings and other utilization management activities, as well as sharing information with employers and other purchasers and patients

21. Other innovative strategies in utilization management that address appropriateness, reduction in health care costs, and quality of care.

Topic/Area Four: Alternative Mechanisms for Payment to Providers Strategies: Insurers' cost management plans may include the following strategies related to provider payment:

- 22. For hospital payment, payment mechanisms may:
 - Encourage competitive pricing
 - Encourage appropriate utilization and use of in-state hospitals, if more cost-effective
 - Encourage use of Centers for Excellence
 - Calculate rates for services provided based on level of needed resources
 - Encourage risk-sharing
 - Make appropriate use of deductibles and co-payments
 - Address the itemization of charges where either "bundling" or "unbundling" would reduce costs.
- 23. For professional payment, payment mechanisms may:
 - Use resource-based payment approaches
 - Encourage "bundled" payment approaches
 - Use deductibles and co-payments
 - Encourage risk-sharing
 - Refer to provider profiles for calculating reimbursement
- 24. For outpatient hospital services, payment mechanisms may:
 - Base fee schedules on resource-based payment
 - Make appropriate use of deductibles and co-payments
 - Require "bundled" billing of services for hospital outpatient services (i.e. all services included in an encounter with a patient can be bundled)
 - Discourage use of emergency room for non-emergency care
- 25. Payment mechanisms may encourage bulk purchasing through competitive arrangements for durable medical equipment, medical supplies, prescription drugs, and other services
- 26. Payment mechanisms may encourage the quality improvement capacities of providers: i.e., coordination, use of practice parameters, training and education of providers and hospitals

27. Other innovative strategies in payment mechanisms that address reductions in cost and administrative burden, and quality improvement of health care

Topic/Area Five: Third Party Liability/Coordination of Benefits Strategies: Insurers' cost management plans may include the following strategies:

28. Data matches to other organizations and insurers that capture relevant data (e.g. Workers Compensation, auto insurance, CHAMPUS)

29. Cost avoidance processing through review of external databases, (e.g., auto insurance, child support enforcement, state retirement system, etc.)

30. Calculation of average savings to cost ratios to determine cost-effectiveness of Third Party Liability/Coordination of Benefits activities

31. Coordination of benefits

- Cost-effective update of COB information files
- Timely response to customer inquiry
- Timely claims processing
- Cost benefit analysis

32. Other innovative strategies in other party liability that address accuracy in claims payment, uniformity, and reduction in costs and administrative burden

Topic/Area Six: Administrative Methods

Strategies: Insurers' cost management plans may include the following strategies:

33. Acceptance of standardized claims formats

- HCFA 1500, Health Insurance Claim Form for medical claims
- HCFA 1450 (aka UB-82, UB-92) Universal Billing Form for hospital claims
- Universal Billing Form (NCPDP-approved) for pharmacy claims
- ADA Dental Form for dental claims

34. Collection of information to support a unified database

- Acceptance of specific patient and provider identification numbers
- Move to provider acceptance of standardized remittance advice formats
- Move to accept standardized Explanation of Benefits (EOB) formats
- Move to accept common local coding requirements
- Accept local field indicators

- Incorporate system edits/audits to validate procedure and diagnosis appropriateness and provider qualifications
35. Acceptance of common coding schemes
- CPT--Common Procedural Terminology
 - HCFA--Common Procedure Coding System (HCPCS)
 - National Drug Codes (NDCs)
 - ICD-9-CM--International Classification of Diseases, 9th Revision, 4th Edition, Clinical Modification, Procedure and Diagnosis Codes
 - DSM III - R--Diagnostic and Statistical Manual III - Revised
 - ADA Dental Procedure Codes, Tooth codes, and Surface Codes
 - Revenue Center Codes
36. Move to adopt Workgroup on Electronic Data Interface (WEDI), or other national efforts towards electronic standardized formats
- Enrollment
 - Eligibility
 - Claims submission
 - Payment and Remittance advice
37. Procedures to conduct internal performance monitoring
- Ongoing review of administrative costs
 - Responsiveness to patients and providers during claims processing and appeals processes
 - Timeliness
 - Responsiveness
 - Measurable claims processing performance standards
 - Timeliness
 - Quality
 - Accuracy
 - Pricing
38. Other innovative strategies in administrative management that address system-wide uniformity, reduction in costs and administrative burden and quality improvement

Topic/Area Seven: Anti-Fraud

Strategies: The cost management features of anti-fraud programs may include the following elements:

39. Fraud and abuse controls, such as:
- Ongoing training of personnel across major functional areas on recognition of potential fraud and abuse situations
 - Formal linkage between provider profiling processes and fraud and abuse detection
 - Education of providers and patients regarding fraud and abuse policies

- Processes to prevent and detect fraud and abuse and seek criminal prosecutions against providers and patients who commit fraud
- Processes to increase patients' awareness of fraud and abuse and to encourage their participation in efforts to detect fraud and abuse (e.g., enclosures with explanations of benefits mailed to patients)

40. Other innovative strategies that address the involvement of providers and patients in control of fraud and abuse, and reductions in insurer costs.

MONTANA INSURERS COST MANAGEMENT PLAN DATA SHEETS

Instructions

In reviewing cost management plans, it will be useful to understand how these plans vary by insurer characteristics such as the number of small group versus large group policies sold, product offerings and deductibles. Therefore, we are requesting that health insurers provide information regarding the number of contracts, covered lives, premiums written, administrative expenses and direct claims incurred *in Montana*, for each product line within the State of Montana's "Disability" categorization, excluding:

Accident only	Credit Disability
Dental	Vision
Specified Disability	Medicare Supplemental
Long Term Care	Disability Income
Automobile Medical Payment	
Workers' Compensation or similar insurance	
Coverage issued as supplemental to liability insurance	

Certainly, product lines will be defined differently by each insurer. So it is the desire of the Authority to obtain useful information regarding the types of health care coverage and varying levels of deductibles offered by insurers.

For Associations, Multiple Employer Trusts, and other group entities, we request that the information regarding contracts be split out into the designated small and large group categories, to the extent possible. In addition, we are requesting that the same information be provided for products that are not underwritten.

If specific, detailed information cannot be provided, we ask that you respond to those areas where information is available and describe any limitations of the data you provide.

For each group categorization listed, please provide the information requested below. All data should be consistent with any data provided to the Montana Commissioner of Insurance. To the extent possible, please adhere to the categorizations provided. If the information is not available in this format, please provide the breakdowns available.

Column

1 *Number of Contracts* - Contract refers to employees or those who receive a certificate of insurance. Many insurers refer to contracts as policies.

Column

2 *Number of Covered Lives* - Please provide the number of covered lives.

Column

3 *Direct Premiums Written* - This refers to the actual premium written for each category during 1992. Please do not annualize premiums for contracts that were not in force for all of 1992.

Column

4 *Administrative Cost* - This refers to incurred expenses associated with claims processing, sales commissions, solicitations, directors' fees, travel and travel items, and legal and auditing. Administrative expense should include salary, benefits and other expenses.

Column

5 *Direct Claims Incurred* - This refers to benefits expense, that is, claims incurred during the year on policies in force.

HEALTH INSURER DATA SHEET

Name of Insurance Company: _____

Federal Identification #: _____

NAIC Identification #: _____

Individual Product Line: _____

Level of Deductible & Co-Payment: _____

Contracts in Force (Use 1992 data)	Number of Contracts	Number of Covered Lives	Direct Premiums Written	Administrative Cost	Direct Claims Incurred
---------------------------------------	------------------------	----------------------------	----------------------------	------------------------	---------------------------

1. Small Group					
a. Individual/1 person group					
b. 2 person group					
c. 3-25 Employees					
d. 26-49 Employees					
2. Large Group					
a. 50-249 Employees					
b. 250-499 Employees					
c. >499 Employees					
Total Contracts	_____	_____	_____	_____	_____
Total Covered Lives	_____	_____	_____	_____	_____

Please call the Montana Health Care Authority at 406/443-3390 if assistance is desired.

ATTACHMENT B

HEALTH INSURER COST MANAGEMENT PLANS

March 24, 1994

Dorothy Bradley
Montana Health Care Authority
28 North Last Chance Gulch
Helena, Montana 59620-0901

RE: American Chambers Life Insurance Company
Cost Management Plans

Dear Ms. Bradley:

Enclosed you will find a narrative description of our cost management program and a set of data sheets.

Please do not hesitate to call me if you have any questions. I can be reached (collect) at (708) 505-4855.

Sincerely,

Linda H. Hickok

Linda H. Hickok
Contracts Attorney

LHH:jlf
enclosures

TOPIC/AREA TWO

9. Through our Preferred Provider Organization contract, our Utilization Review Program, and Medical Case Management, we work to develop a program of insurance that provides our customers with:
 - . accessibility of discounted provider services (PPO)
 - . appropriateness of care for the medical condition (UR, MCM)
 - . outcomes of treatment provided (MCM)
 - . correspondence with physicians concerning treatment practices noted by our rebundling software.
7. Our medical case management vendor works closely with severely or terminally ill patients and their families to ensure the highest quality of medically necessary patient care. Medical case management also helps in the coordination of care between the physicians, nurses and healthcare facilities. Case managers work closely with patients and families to ensure patient comfort, appropriateness of treatment, and cost management.
8. We rely on the Preferred Provider Organization to perform evaluative functions.
10. N/A

TOPIC/AREA THREE

13. A portion of our Utilization Review program focuses on precertification of hospital confinements. This program documents the medical necessity of inpatient setting for treatment. Admissions for elective procedures that may be appropriately rendered in outpatient setting are not certified. Another portion of the UR program requires Second Surgical Opinions on elective surgical procedures and directs customers to local, contracted physicians for second surgical opinions.

Company has established an appeal process through our Claim Review Board..

14. The Hospital Precertification portion of our Utilization Review program will certify additional inpatient hospital days when circumstances warrant extended treatment.

Company has established an appeal process through our Claim Review Board.

12. Utilization Review vendor alerts ACLI of inpatient admissions for catastrophic illnesses and injuries, and other situations where patient may benefit from case management.

Case managers coordinate and facilitate treatment between physicians and facilities, including home health care. Cases are assessed on a monthly basis for appropriateness of care and patient progress. Patient and family have right to accept or reject case management.

Company has established an appeal process through our Claim Review Board.

11. Cost containment rebundling software system reproduces the consensus decisions of clinically active practitioners in regard to current trends and service delivery patterns.

Utilization Review vendor profiles acceptable performance standards. May waive procedural requirements in consideration of extenuating circumstances.

15. Discharge planning may occur under Utilization Review, or Medical Case Management may be implemented for patients with special needs.

Company has established an appeal process through our Claim Review Board.

19. Prescription drug utilization is monitored by a third party. Substitution with generic drugs is encouraged through built in incentives (i.e., lower deductibles or copays for generic drugs).

17. Select claims are processed through rebundling software. Inappropriate billing codes are rejected.

16. The Second Surgical Opinion portion of the Utilization Review program includes mandatory reviews for elective surgeries that are performed frequently, or that may be inappropriate .

Company has established an appeal process through our Claim Review Board.

18. Retrospective Reviews are processed by a third party.

20. Utilization Review company provides statistical analyses of this company's experience, costs and savings, as well as national utilization statistics.

In addition, in-house audits are performed and compared to UR company's reports.

21. N/A

TOPIC/AREA FOUR

22. The use of Preferred Provider Organization member hospitals is encouraged through incentives built into payment mechanisms.

Hospital bills received from non-member facilities are often referred to an outside consultant to negotiate discounts.

23. Fees for professional services are subject to reasonable and customary allowances. Reductions are triggered by zip codes and procedure codes.

Bills with questionable billing codes are processed through rebundling software.

The use of Preferred Provide Organization member physicians is encouraged by increased coinsurance percentages.

24. Bills for outpatient hospital services are often referred to an outside consultant for negotiated discounts.

Use of PPO member hospitals is encouraged through reduction of the insured's coinsurance percentage.

New plans include provisions discouraging emergency room care. These provisions do not apply when patient is admitted to hospital.
25. Medical Case Management personnel negotiate discounts for durable medical equipment, home care nursing, IV infusion, RX drugs, and other medical supplies/services.
26. Preferred Provider Organization and rebundling software package vendor communicate with providers concerning practice parameters.
27. N/A

TOPIC/AREA FIVE

30. Evaluations of cost-effectiveness are provided by our Preferred Provider Organization and Utilization Review company.
31. We attain optimum savings by utilizing full Coordination of Benefit provisions.
28. Internal coordination of benefits procedures are compatible with other organizations and insurers.
29. N/A
32. N/A

TOPIC/AREA SIX

37. Administrative performance is monitored using data systems documents reporting:
 - . productivity
 - . inventory
 - . pending

Processing performance is monitored through audits.
35. Common coding schemes accepted are CPT, HCFA (HCPCS), ICD-9-CM, DSM III-R and Statistical Manual III, and ADA codes. National Drug codes and Revenue Center Codes are not accepted.
36. We are implementing a new claims processing software system that will allow electronic data interface.

34. Tax identification numbers of providers are indexed in software.

We accept national standardized formats. It is cost-prohibitive to accept local coding formats.

We are implementing a new software program with libraries of procedure and diagnostic codes.

33. All of the standard forms noted are accepted.

38. N/A

TOPIC/AREA SEVEN

39. ACLI's Security Department, which is responsible for anti-fraud programs:

- . conducts investigations when there is evidence of fraud
- . provides employees with educational materials concerning how to detect potential fraud or abuse
- . elevates customer awareness of fraudulent practices



AMERICAN NATIONAL INSURANCE COMPANY

JOHN J. ROONEY, ALHC, ASSISTANT VICE PRESIDENT, DIRECTOR GROUP LEGAL/AUDIT
ONE MOODY PLAZA GALVESTON, TEXAS 77550-7999 409/766-6539

March 17, 1994

VIA FACSIMILE:
(406) 443-3417
AND FIRST CLASS MAIL

Dorothy Bradley
Montana Health Care Authority
PO Box 200901
Helena, Montana 59620-0901

Re: Cost Management Plan

Dear Ms. Bradley:

Supplementing your recent discussion with Mike Moriarty of American National, enclosed is our Cost Management Plan and related Health Insurer Data Sheets.

Should any questions arise concerning these items, please contact me.

Sincerely,

John J. Rooney

enclosures
xc: M. Moriarty
G. Tolman

COST MANAGEMENT PLAN

for

Montana Health Care Authority

American National Insurance Company
Galveston, Texas

March 15, 1994

Integrated Systems for Health Care Delivery

Benefit Plan Features

American National conducts ongoing development of benefit features that encourage, principally via financial incentives to the consumer, alternative care settings and appropriate levels of care for the diagnosis and degree of medical necessity involved:

- deductibles and co-payments
- pre-authorization requirements
- inpatient limits through utilization review
- preventive health care options
- home health care

Provider Networks

We have developed and will continue to seek additional provider network affiliations offering cost containment while maintaining the overall quality of health care services.

Quality Improvement and Assessment

- All proposals by network and other contract providers are reviewed for evidence of QC programs incorporating provider profiling, care quality assessments, patient appeal mechanisms, etc. Existing provider-affiliates are encouraged to develop and enhance such programs.
- As the overall liability/regulatory climate and resulting market conditions permit, in-house provider profiling data and techniques will be developed to help ensure provider performance standards and consumer satisfaction.

Utilization Management

Pre-Admission Review/Concurrent Review

Pre-admission review is a requirement in many policies, with insureds facing financial disincentives for non-compliance. Concurrent review is also common in American National plans. Confinements are reviewed based on diagnosis, the patient's history, etc.; lengths of stay are authorized accordingly. Expenses for services provided beyond the authorized limits are typically excluded, with insureds having appeal rights in most cases.

Large Case Management

Case management techniques are utilized in chronic illness and catastrophic illness/injury claims to help assure the availability of adequate, yet appropriate care. This includes the direct involvement of trained health care professionals, often on-site, interacting with the patient, family members, attending physicians and other providers to establish suitable care settings, practitioners, etc.

Retrospective Audits

These audits are conducted regularly, on a random basis, to identify billing errors and abuses by health care facilities. Some benefit plans include rebate programs to encourage consumers to help identify inaccuracies or questionable billing practices.

Provider Profiling

American National is currently reviewing the adoption of provider profiling techniques for utilization comparisons and other quality control purposes. Such measures will be adopted as data collection and automated system capabilities are enhanced.

Utilization Review Data Tracking

Presently American National subscribes to or independently maintains sample fee studies and similar UR aids for comparing fees and treatment programs to established norms. Development of other data maintenance and tracking techniques to monitor utilization patterns, and to provide detailed cost/savings analyses, etc., is planned.

Alternative Provider Payment Mechanisms

Policy Design

- Deductibles, patient co-payments and other cost sharing devices are used to increase consumer awareness of costs and treatment/product alternatives.
- Benefit penalties are often included to discourage medically unnecessary or casual use of inpatient and emergency facilities.
- Mail order and other discount prescription drug programs are available, providing substantial savings on bulk purchases of maintenance drugs, etc.

Claim Processing

- Benefit allowances for professional services are determined in part by comparisons with geographically-based sample fee data. Charges exceeding these "usual and customary" benchmarks are excluded, increasing consumer awareness of the variety of pricing trends and methods among providers.
- American National has implemented and will continue to develop audit techniques to identify and counter unbundling and other questionable billing schemes prevalent within organized medicine.

Third Party Liability/Coordination of Benefits

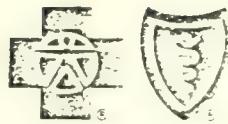
- Claim and eligibility data supplied by claimants, providers and other sources are compared to identify potential third party liability, workers' compensation and COB sources.
- In those jurisdictions where subrogation and similar approaches are permitted, cost-effective recovery is aggressively pursued.
- American National actively participates in data match programs conducted by Medicare intermediaries, etc., often reducing or eliminating overinsurance in specific cases.

Administrative Methods

- All standard forms (e.g., HCFA 1500, UB82, UB92, ADA forms) are accepted. Only where unusual circumstances exist (third party liability, litigation, workers' compensation) is additional information sought.
- All generally accepted coding schemes (e.g., CPT, ICD-9 CM, DSM-III, ADA) are recognized.
- Administrative procedures and costs are regularly reviewed to maintain cost-effective quality of service.

Anti-Fraud Efforts

- Claim processing edit criteria undergo continuing development to help identify questionable claims and abusive provider billing practices. Treatment duration and frequency, medical appropriateness, demographics and other factors are examined.
- Full cooperation is given the appropriate regulatory or law enforcement authority in aggressively investigating suspected fraudulent activity.



BlueCross BlueShield of Montana

404 Fuller Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

Customer Information Line:
1-800-447-7828

March 15, 1994

Charles Butler, Jr.
Vice President
External Affairs

Dorothy Bradley, Chair
Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

RE: Health Insurer Cost Management Plans

Dear Ms. Bradley:

Enclosed is the Blue Cross and Blue Shield of Montana Cost Management Plan, the specifications for which were received January 25, 1994. Because we were not on the initial mailing of the specifications, an extension to March 15 was given.

Blue Cross and Blue Shield of Montana provider networks form the basis for our organization. Consequently our discussion of networks appears first in the report.

Our initial statistical information is aggregate data based on product line as defined in Exhibit A. Product line information was requested in the specifications. Additional demographic and utilization information is being prepared in a format requested by your consultant, HSR, Inc.

We submitted demographic information about our community rated market, employers with between 3 and 25 employees, on March 2. A copy of the information is included as Exhibit C. Enclosed as Exhibit B is information about the Montana Comprehensive Health Association. We serve as the administrator of this high risk pool—a state-sponsored program.

If you, other members of the Authority, your staff or consultants have questions about this submission, please contact me or Tanya Ask at 444-8297.

Sincerely,

A handwritten signature in black ink, appearing to read "Charles Butler, Jr." followed by a date.

Charles Butler, Jr.
(406) 444-8263

210TA314.1N/ct
Enclosures
cc: Tanya Ask

**Cost
Management
Plan**

Blue Cross and Blue Shield of Montana
March 15, 1994

Cost Management Plan

Table of Contents

Introduction	i
Networks for Delivery and Reimbursement of Health Care Services	2
Utilization Management	6
Alternative Mechanisms for Payment to Providers	10
Third Party Liability/Coordination of Benefits	13
Administrative Methods	15
Quality Assessment and Improvement	18
Anti-Fraud Activities	20
Health Insurance Data Sheet	Exhibit A
Montana Comprehensive Health Association Annual Reports	Exhibit B
Health Benefit Committee Small Employer Information	Exhibit C
Blue Cross and Blue Shield of Montana Provider Network Listing	Exhibit D

INTRODUCTION
BLUE CROSS AND BLUE SHIELD OF MONTANA
COST MANAGEMENT REPORT
MARCH 15, 1994

Blue Cross and Blue Shield of Montana strongly believes that reform of both health care financing and delivery in Montana and the rest of the United States is necessary. We supported Senate Bill 285, Montana's reform initiative in 1993, and in compliance therewith file this Cost Management Report.

Our company, a non-for-profit health service corporation authorized under 33-30-108, MCA, transacts the business of health care benefit financing and administration in the State of Montana only. We are subject to financial, market conduct, licensing, insurance product filing and approval, and other insurance laws of this state. Blue Cross and Blue Shield of Montana currently covers or administers health benefits for approximately 235,000 Montanans.

We are one of 69 independent Blue Cross and Blue Shield plans and a member of the Blue Cross and Blue Shield Association. The Association sets financial standards and timeliness and accuracy standards for the administration of health benefits. Through the Association we have national responsibilities and accountability, as well as accountability to the people of Montana.

As a health service corporation we are governed by a board of directors composed of eight Montana consumers and payers, five physicians and two hospital administrators. In operation for over fifty years providing health benefits to Montana residents, our services are delivered through a provider network: physicians, hospitals, optometrists, social workers, psychologists, nurse anesthetists, nurse practitioners, physician assistants, and dentists. Services for approximately 13,000 are provided through HMO MontanaSM, a unique network of personal care physicians. To date, HMO Montana is the State's only active health maintenance organization. We also have unique programs in Montana such as: Montana HealthLinkSM, preferred provider organization with Deaconess Medical Center in Billings; an inpatient psychiatric network composed of St. Peter's Community Hospital, St. Patrick Hospital, and Deaconess Medical Center; and a chemical dependency preferred provider network consisting of nine inpatient and outpatient providers throughout Montana. A copy of our Provider Network Listing is incorporated as Exhibit D.

The employees, management and Board of Blue Cross and Blue Shield of Montana believe in the ability of the people in this state to solve our problems. This is not a simple task, but Blue Cross and Blue Shield of Montana will continue to strive toward our corporate purpose:

It is the mission of Blue Cross and Blue Shield of Montana to support the delivery of quality health care and other benefits and services to our customers through cost effective relationships with providers, government and other appropriate entities.

COST MANAGEMENT PLAN

Topic: Networks for Delivery and Reimbursement of Health Care Services

Blue Cross and Blue Shield of Montana plays a major role in managing both the health care benefits and medical services provided to our members. Physician and hospital networks have been an integral part of Blue Cross and Blue Shield of Montana since our inception. The Plan has made the development, implementation, and expansion of new provider networks a primary corporate priority in the 1990s. The effort has included a major expansion of the Plan's Managed Care functions—which now manage the benefits of more than 200,000 Montanans—and pioneering negotiations with health care providers across Montana that will fundamentally change the way medical care is received and paid for in our state.

Early in this effort, Blue Cross and Blue Shield of Montana introduced Managed Care MontanaSM. Preadmission review, concurrent review, and individual case management all are important components of Managed Care Montana. With these review and benefit management strategies, Blue Cross and Blue Shield of Montana can provide benefits for members who have extensive or critical health care needs, assuring that the highest quality, most appropriate care is delivered in the most cost-efficient settings.

Blue Cross and Blue Shield of Montana has also been a leader in support of wellness activities over the years. While health promotion is a key component of the benefits provided under the company's Managed Care services, it is important to note that the Plan has historically reached beyond its own members in encouraging and supporting health promotion and wellness activities for all Montanans.

Benefit Packages That Promote Coordinated Care

- Through its managed benefits, Blue Cross and Blue Shield of Montana gives members strong financial incentives to select health care professionals from a network of providers. The network includes not only Member doctors and hospitals, but also optometrists, podiatrists, social workers, psychologists, CRNAs, physician assistants, nurse practitioners, and dentists. Each provider network ensures that members will gain access to local care whenever possible.

- The Plan's health maintenance program, HMO Montana, coordinates the care provided to members through their primary care physician—who functions as the member's medical manager and health care services "gatekeeper." The physician provides routine and preventive care and may refer the member to a Blue Cross and Blue Shield of Montana contracting specialist or other health care providers as necessary. Prescription drug services are provided through a contracting network of HMO Montana pharmacies.
- The HMO Montana Primary Care Physician is paid on a capitation basis, eliminating the inflationary fee-for-service structure for primary care services and implementing a more coordinated approach to health service delivery and provider payment. The Primary Care Physician's management responsibilities are factored into the capitation amount.
- Two special networks, one comprised of inpatient psychiatric services, and the second of both inpatient and outpatient substance abuse services, provide comprehensive care and treatment for members. The arrangements were implemented to assure appropriate intervention and cost-effective treatment in the most effective and least costly setting.

Health Education

- As Montana's dominant private health insurer—providing benefits to nearly half of the State's insured population—Blue Cross and Blue Shield of Montana has always seen itself as an important resource for the state in the area of health education and wellness. The Company believes it has a responsibility to contribute to the well-being of all Montanans through these programs, such as the Governor's Cup, now in its twenty-first year. The Governor's Cup has grown to almost 7,000 participants of all ages.
- In making health education available statewide, the Plan has worked with the Montana Health and Environmental Science Department over the years, providing ongoing support for the Department's efforts to promote immunizations for school age children. These efforts have benefitted thousands of young Montanans.
- Blue Cross and Blue Shield of Montana joined with Healthy Mothers, Healthy Babies, and the State of Montana Department of Health and Environmental Sciences and Social and Rehabilitative Services several years ago to launch the Baby Your Baby program that has benefitted hundreds of pregnant women and newborns.
- We have been a major sponsor of three statewide AIDS education conferences.
- Educational materials including Take Care of Yourself, a medical handbook promoting healthy living, and numerous topic-specific brochures have been made available to our members. Education and wellness articles appear in each of our quarterly newsletters which are developed specifically for senior citizens, labor groups, and employees.

- Health education and health risk assessment programs are available to employers interested in addressing health risks or injuries specific to their employees and work place.
- Members of HMO Montana are eligible to receive discounts at fitness clubs.

Provider Networks that Consider Cost-effectiveness

- Blue Cross and Blue Shield of Montana has negotiated cost-saving agreements with inpatient psychiatric facilities and chemical dependency centers. The Plan has negotiated cost-saving arrangements for home health services and out-of-state providers caring for severely ill Montanans in need of services not available in our state.
- The HMO Montana prescription drug benefit includes cost-saving contractual agreements with over 150 Montana pharmacies.
- Blue Cross and Blue Shield of Montana enthusiastically supports, within the limits of existing licensure requirements, the use of physician extenders and allied health professionals when their expanded use offers a greater potential to both improve accessibility and save money without sacrificing quality.
- Montana HealthLink, the Blue Cross and Blue Shield of Montana hospital-based preferred provider arrangement with Deaconess Medical Center in Billings, has enabled Yellowstone County area employers and their employees to pay reduced insurance premiums when they choose this program. This is a savings to both employers and employees in their cost of health benefits.
- Blue Cross and Blue Shield of Montana, with the cooperation of over 30 hospitals and 550 physicians, began the Caring Program for Children in January 1, 1993. This program provides preventive and primary care benefits to children not otherwise covered for health care services. Through a network of Caring Program professionals and hospitals, services are paid at reduced rates by the Caring Foundation. Nearly 300 Montana children have benefited from this program.

COST MANAGEMENT PLAN

Topic: Utilization Management

Blue Cross and Blue Shield of Montana has one of the most progressive and sophisticated utilization management programs in the state. The programs are administered by our Health Benefits Management Department, whose professional staff includes practicing physicians, registered nurses, registered records administrators, and licensed practical nurses. All Blue Cross and Blue Shield of Montana indemnity products include benefits management programs such as certification review, individual case management, and pre and post payment claims utilization review.

We plan to build utilization management systems which involve partnerships, including physicians, hospitals and other providers. The partnerships will allow providers to take financial risk in exchange for freedom from the intense micromanagement associated with previous utilization management programs.

Our appeals process, in compliance with Title 33, Chapter 32, MCA, allows our members or participating providers a well defined process for questioning any of the Plan's utilization management decisions.

Case Management

- Flexible use of benefits to solve health care delivery problems in the most cost-efficient manner remains the single best source for managing costs in our managed care plans. Case Management coordinators are on-site in several larger Montana communities.
- Individual Case Management, administered by the Blue Cross and Blue Shield of Montana Managed Care Montana program and incorporated into coverage now provided to 200,000 plus Montanans, provides quality care while containing costs for members who have catastrophic illnesses or injuries. In conjunction with the member's physician, the treatment team, and the patient's family, Blue Cross and Blue Shield of Montana aggressively pursues treatment options that aid recovery and maximize cost savings--even when such options are not specifically outlined in the member's certificate.
- Nurses and Physician Consultants in the Blue Cross and Blue Shield of Montana Managed Care Montana program identify the treatment goals, and locate and assess medically appropriate settings. Alternatives might include home health care, outpatient treatment, and specialized rehabilitative services in addition to ongoing monitoring of patient progress.

Preadmission and Admission Review

- These activities are a feature of all of our Benefit plans. Identification of cases for Individual Case Management comes largely from these processes.

Concurrent Review and/or On-site Review

- Our managed care programs include concurrent review for all hospitalizations. Through our certification review activity we have avoided unnecessary admissions and extra inpatient days. Case Management has, however, proved to be the most cost-effective benefit.

Discharge Planning

- Where appropriate, we participate in discharge planning to guide patients to appropriate care. Our Managed Benefits Plans allow some flexibility in providing these benefits.

Utilization Review

- Pre and post payment claims review, utilizing edits within the claims system, verify that employer negotiated benefit design and payment rules and limits are followed.

Medical Policy Development

- A registered nurse within the Health Benefits Management Department is dedicated to Blue Cross and Blue Shield of Montana medical policy research.
- A formal committee comprised of Plan physicians and outside consultants, nurses, and representatives from departments directly impacted by reimbursement issues meet monthly to review medical policy research and make policy decisions that serve our members' needs.
- An exhaustive list of resources, including medical literature, national professional medical specialty organizations, specialty organization position papers, medical policy from other Blue Cross and Blue Shield Plans, and the Blue Cross and Blue Shield Association Technology, Evaluation and Coverage (TEC) program is considered in the development of medical policy.

HMO Montana Personal Care Physician Application and Quality Assurance Process

- Each physician who applies to become an HMO Montana Primary Care Physician must meet specific education criteria, undergo a review of his or her practice patterns, and receive approval from the HMO Montana Medical Director.
- Credentialing criteria include licensure in the State of Montana, participation as a Blue Cross and Blue Shield member physician, hospital admitting privileges, an acceptable method of on-call coverage, and a specified minimum level of malpractice insurance coverage.
- Patterns of care and the cost of services provided are reviewed and monitored by the HMO Montana Primary Care Physicians within their own community.

HMO Montana PCP Patient Satisfaction

- HMO Montana randomly selects members and employer groups for participation in satisfaction surveys on an annual basis.
- Information received through these surveys is considered in modifying HMO Montana benefit plans and business processes.

COST MANAGEMENT PLAN

Topic: Alternative Mechanisms for Payment to Providers

Blue Cross and Blue Shield of Montana recognizes that integrated networks or cooperative systems of delivery and reimbursement of health care can help control costs and provide a framework for focusing on the important areas of health care outcomes and customer satisfaction. These networks would include physicians, hospitals, allied health care providers, and Blue Cross and Blue Shield of Montana.

Hospital Inpatient Payment

- Blue Cross and Blue Shield of Montana has a prospective payment agreement with one of Montana's largest hospitals. This hospital is reimbursed on a Diagnostic Related Groups (DRG) basis for most services. Prospective payment provides incentives for appropriate utilization of hospital services (unbundling is not an issue since reimbursement is not based on the number of services), and in conjunction with the Plan's utilization review activities helps assure timely discharge of patients from the hospital. Under prospective payment hospitals are at risk to the extent the cost per case/day exceeds the negotiated rate. This prospective payment method provides both hospital and payer with greater predictability in the amount of claims which will be covered—greater predictability in determining premium rates. Services not reimbursed under DRGs are paid based on a negotiated rate.
- Blue Cross and Blue Shield of Montana offers a number of products with varying levels of hospital copayments and deductibles.
- In addition to its negotiated payment arrangement with hospitals, Blue Cross and Blue Shield of Montana has been an active participant in the Montana Hospital Rate Review System, a system established to monitor hospital financial viability. Blue Cross and Blue Shield of Montana has used this forum to monitor hospital budgets.
- Based on our agreement with each Montana hospital, Blue Cross and Blue Shield of Montana has an agreed upon rate of payment with each hospital.

Hospital Outpatient Payment

- A negotiated cost-saving payment program has been arranged with a number of hospitals for diagnostic x-ray and laboratory services provided to Blue Cross and Blue Shield of Montana patients.

Physician Payment.

- For HMO Montana, Blue Cross and Blue Shield of Montana uses two physician payment mechanisms that encourage risk-sharing and discourage unbundling. Primary care physicians who serve as patient managers receive a monthly capitation amount for primary care services provided to their patients. In addition, primary care physicians

are also subject to a withhold of a percentage of fees for the specialty services they provide. (Specialty services are reimbursed using the Blue Cross and Blue Shield of Montana prevailing fee allowances.)

- In addition to the strategies outlined above, Blue Cross and Blue Shield of Montana has also established a reasonable fee allowance system. Participating physicians are only reimbursed up to this allowance and may not bill patients for the balance of charges. Fees are reviewed annually and updated as appropriate. Increased emphasis is placed on the importance of primary care services in the annual pricing update.
- Without abandoning the savings achieved through the reasonable fee allowance system, Blue Cross and Blue Shield of Montana is moving to a comprehensive Resource-Based Relative Value System (RBRVS), which balances cognitive services and procedural services to arrive at more equitable professional reimbursement.

COST CONTAINMENT PLAN

Topic: Third Party Liability/Coordination of Benefits

Blue Cross and Blue Shield of Montana has an aggressive and effective other-party liability function, which saves Plan members dollars each year. Our third-party liability, coordination of benefits, and subrogation of benefits efforts are part of our Claims Department. They include aggressive and unique referral and screening methods to pursue every source of appropriate payment available from other payers or insurers.

Calculation of Average Savings to Cost Ratios to Determine Cost-effectiveness of Third-party Liability/Coordination of Benefits Activities

- The Plan, on a monthly basis records and analyzes average savings to cost ratios of its other-party liability functions. This information is also evaluated on an ongoing basis using standards established by the National Management Information Systems (NMIS) program, which was developed by the Blue Cross and Blue Shield Association.

Coordination of Benefits

- For group insurance, the Plan's coordination of benefits information files are updated on an ongoing basis through reverification of enrollment and membership data, and also through investigation of claims material. The timeliness of its claims processing and customer service responsiveness in this area is monitored monthly both by the Plan, and by the National Blue Cross and Blue Shield Association, using standards developed by the NMIS program.
- The Coordination of Benefits Program is operated in compliance with the rules issued by the Montana Insurance Department, which are patterned after those issued by the National Association of Insurance Commissioners (NAIC). Through use of NAIC rules, member claims are treated in a consistent manner by most insurers.

Other Party Liabilities

- The Plan has developed a sophisticated screening and referral system for the aggressive pursuit of other-party liability for medical services provided to its subscribers. All claims forms include questions relevant to this effort, such as whether the injury being treated was work-related, and whether the patient has other insurance, etc. Additionally, formal or informal structures are in place for the referral of claims and/or cases to the other-party liability unit by the Plan's Provider Relations Department, Customer Service Department, Utilization Review, and Claims Staff. All claims that "suspend"--cannot immediately be processed due to lack of information--are routinely investigated for other-party liability potential.

COST MANAGEMENT PLAN

Topic: Administrative Methods

Blue Cross and Blue Shield of Montana is committed to the highest standards of administrative and operative efficiency, and has systems in place that require that we routinely monitor and track our effectiveness in this area. Generally, these systems demonstrate a high level of efficiency and of customer satisfaction.

The Plan's performance in claims processing and customer service is monitored daily and periodically charted using several instruments.

Our members are not required to file a claim form for benefit payment of member provider services. We accept and use most standardized claims formats, and strongly support efforts to further standardize definitions and forms in the health insurance industry. Blue Cross and Blue Shield of Montana does not require that its Medicare Supplement members file claim forms. Medicare A and B claims administration electronically file with Blue Cross and Blue Shield of Montana, assuring that we receive all member claims. A number of hospitals and professional offices also file claims with us privately.

Acceptance of Standardized Claims Formats

- Blue Cross and Blue Shield of Montana currently accepts the HCFA 1500 for medical claims and the HCFA UB92 for hospital claims. As part of administrative simplification, we would recommend that all claims submitted by health care professionals and facilities adhere to these two forms.

Acceptance of Common Coding Schemes

- CPT/HCPCS is the accepted procedure code on claims that are processed by Blue Cross and Blue Shield of Montana. We supplement these codes with a few local codes which define benefits not available on a HCPCS. ICD-9 procedure codes are used on the UB92.
- ICD-9 diagnosis codes are currently used by Blue Cross and Blue Shield of Montana. These diagnosis codes are acceptable on any claim except mental health claims which use DSM III-R codes.
- Revenue Codes as defined by HFMA in the UB92 billing instructions are required on all facility claims.

Electronic Claims Capabilities

- We are a leader in Montana in the area of paperless claims processing. More than 61 percent of all Blue Cross and Blue Shield of Montana claims from health care facilities and more than 44 percent of all Blue Cross and Blue Shield of Montana professional provider, including physicians and optometrists, claims are now submitted to the Plan electronically.
- Blue Cross and Blue Shield of Montana also administers the Medicare A and B programs in Montana, and has worked with physicians and hospitals on electronic claims submission. Over 60 percent of all Medicare professional provider claims are submitted electronically. Ninety-two (92) percent of Medicare hospital claims and 56 percent of skilled nursing facility claims are billed electronically.
- Medicare B is also in trials testing for the feasibility of using Ocular Character Recognition (OCR) technology.

Move to Adopt Workgroup on Electronic Data Interchange (WEDI), or Other National Efforts

Toward Electronic Standardized Formats

- Recognizing the importance of the Workgroup on Electronic Data Interchange recommendations, Blue Cross and Blue Shield of Montana is moving toward adoption of WEDI—recommended electronic standardized formats for enrollment, eligibility, claims submission and payment and the remittance advice.

Out-of-Area Claims Processing

- As of April 1, 1994, Blue Cross and Blue Shield of Montana will participate in the "Out of Area" claims processing program sponsored by the Blue Cross and Blue Shield Association. Through Interplan Teleprocessing Services software, claims for Blue Cross and Blue Shield subscribers will be processed in the state where the services are rendered. For Montana providers this means that all Blue Cross and Blue Shield of Montana Plan claims can be sent to us for processing, dealing with one instead of 69 plans. We can also address all questions on patient benefit verification and eligibility.

COST MANAGEMENT PLAN

Topic: Quality Assessment and Improvement

The Plan's administrative costs are routinely reviewed bimonthly by the Board of Directors. The corporate plan and budget are approved annually by the Board, which has a standing Finance Committee to closely monitor and evaluate finances.

Blue Cross and Blue Shield of Montana has a comprehensive review program to monitor and evaluate its responsiveness in connection with its claims processing and appeals. Through the National Management Information Systems (NMIS) program developed by the Blue Cross and Blue Shield Association, responsiveness to questions that the Plan receives either by telephone or inquiry is collected and measured against performance standards, then compared to the other 68 Blue Cross and Blue Shield of Montana Plans. The measures include both the timeliness of the Plan's response, as well as the accuracy of the response. Surveys are conducted of subscribers who have sought assistance from the Plan, and submitted twice annually for review by BCBSA.

The Plan, on a monthly basis collects and measures both timeliness and accuracy of claims processing functions. The information is compared to national standards set by BCBSA, as well as to the performance of other Plans across the country.

Performance Monitoring by External Organizations

- Information reflecting activities within the Claims and Customer Service Departments and the activity and savings associated with coordination of benefits, Workers' Compensation investigation, subrogation, Managed Care, and application of reimbursement policies is included in a quarterly cost-containment report filed with Blue Cross and Blue Shield Association. This information also provides performance standards used in comparisons with other Blue Cross and Blue Shield Plans.
- The Internal Audit Department also works with those customers, such as the State of Montana, that contract with outside consultants to audit administration of employees' health benefits programs.
- The Department also works with the Montana Department of Insurance, which by law conducts routine financial examinations of the Plan's operations.
- As a Health Service Corporation, Blue Cross and Blue Shield of Montana is subject to a market conduct examination at least quadrennially. This requirement does not extend to other third party payers in Montana.

COST MANAGEMENT PLAN

Topic: Anti-Fraud Activities

The Plan's Internal Audit Department has responsibility for anti-fraud functions. Insurance fraud costs all consumers of health benefits, so its detection is an important part of cost containment. The deterrence and detection of claim fraud is accomplished in the following ways.

Toll-free Fraud Hotline

- The Plan investigates all complaints received.

Claim Quality Assurance Program

- The Plan statistically samples claims on an ongoing basis.

Periodic Review of Payment Patterns

- The Plan conducts periodic reviews and analyses of claims activities and payment patterns. Variances and aberrations are investigated.
- Subscriber validation of services billed is conducted.
- Hospital bill audit programs are utilized.

Automated Edits

- The majority of claims that are processed by the Plan are adjudicated by the Claims System, which incorporates various complex automated edits that minimize the risk of fraud. Claims that do not pass all of the system edits are suspended for manual investigation or payment is denied. The system editing is essential to a strong fraud prevention program.

Explanation of Benefits

- Plan subscribers are issued Explanation of Benefit (EOB) forms that describe health care services provided and claims filed. Subscribers are encouraged to examine these forms for accuracy and to notify the Plan of discrepancies.

April 20, 1994

C-38

900 Cottage Grove Road
Bloomfield, CT 06002
Telephone 203.726.7687
Facsimile 203.726.5400

Ms. Dorothy Bradley
Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

RE: Cost Management Plans

Dear Madam:

Enclosed is our response to the above captioned request. This response includes information about Connecticut General Life Insurance Company and CIGNA HealthCare companies' practices for the areas identified in the guidelines. We were not able to provide you with all the data requested in the Health Insurer Cost Management Plan Data Sheets as it is not readily available from our systems. We do not collect the exact number of employees insured under a group policy but categorize policies by the group size band (i.e., Small Group and Large Group). We currently have no Small Group medical or life contracts in the state of Montana. The Large Group cannot be broken out by the number of employees. Also, the level of deductible and co-payment is not available since this information may vary from account to account and from different plans within each account.

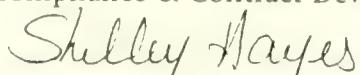
We apologize for the delay in sending this information to you and appreciate your cooperation. Since numerous departments were involved, it took us some time to compile the information necessary to respond to your request.

If you have any questions, please feel free to contact Shelley Hayes at (203) 726-6050 if you have any questions.

Very truly yours,



Patricia K. Julian, Assistant Director
Compliance & Contract Development, C-38



By: Shelley Hayes, CCD Analyst
Compliance & Contract Development, C-38

TABLE OF CONTENTS

INTEGRATED SYSTEMS FOR HEALTH CARE DELIVERY	SECTION I
INTEGRATED SYSTEMS	SECTION II
QUALITY IMPROVEMENT AND ASSURANCE	SECTION III
ALTERNATE MECHANISMS FOR PAYMENT TO PROVIDERS	SECTION IV
UTILIZATION MANAGEMENT	SECTION V
ADMINISTRATIVE METHODS	SECTION VI
THIRD PARTY LIABILITY/COORDINATION OF BENEFITS	SECTION VII
ANTI-FRAUD	SECTION VIII

INTEGRATED SYSTEMS FOR HEALTH CARE DELIVERY

Since health care is delivered and accessed on a local basis in this country, there are variations in practice patterns and in preferences for delivery systems. So one type of managed care product will not meet all employers' needs. Therefore, we have designed a complete portfolio of Managed Care products in response to the need for a variety of approaches to controlling health care costs. Our spectrum of products includes indemnity programs with cost containment features, PPOs, HMOs, FlexCare and other innovative products. Our HMO and FlexCare products utilize a "gatekeeper" approach where the primary care physician controls the care a patient receives.

MEDICAL PRODUCTS

Over the spectrum of our products, Managed Care Indemnity provides the least amount of cost control with our HMO product providing the most amount of cost control. The following products are described in the order of their place in the spectrum.

Managed Medical Indemnity - A traditional, fee-access indemnity product with built-in cost containment features administered by Intracorp, a CIGNA subsidiary and leading provider of utilization review services. Intracorp services include: Pre-Admission Certification, Continued Stay Review, Hospital Bill Audit, Discharge Planning, Medical Case Management, Prospective Procedure Review, and many other programs. An optional preventive care benefit which includes well woman care and well baby care (up to age 2) is available to the policyholder.

This product may be insured by Connecticut General Life Insurance Company or may be self-insured and administered by Connecticut General Life Insurance Company.

Preferred Provider Program (PPO) - A managed health care product that is like traditional medical indemnity plans in that it is an indemnity product with plan design features like deductibles, coinsurance and out-of-pocket limitations. Like an HMO, the PPO has a network of contracted participating providers who agree to accept discounted reimbursement rates. The PPO benefit plan is designed to direct patients to a more cost effective health care environment than offered by traditional indemnity plans. The PPO offers incentives like higher reimbursement levels to encourage participants to select PPO providers when they and their family members need medical care. PPO arrangements do not affect which medical services are covered, but how the services are covered. The expenses covered and any coverage limitations are contained in the group insurance contract and the employer can determine the benefits to be included in their plan. The PPO arrangement applies to the fees providers charge and how much insureds are reimbursed for covered medical services. PPOs also include the full range of utilization management services described in the Managed Medical Indemnity program.

This product may be insured by Connecticut General Life Insurance Company or may be self-insured and administered by Connecticut General Life Insurance Company.

FlexCare Stand-Alone Designated Provider Program (DPP)* - A "gatekeeper" PPO product that uses CIGNA Healthplan (CHP) provider network with point-of-service opt-out coverage. All employees must choose a designated primary care physician from the CHP network. The plan is designed with financial incentives to channel the delivery of care to cost-effective, quality network providers, but if employees choose to opt-out of the network at the point-of-service, they will be covered at a lower level of benefits. The out-of-network coverage also reflects managed care features (e.g. SOS, PAC, etc.). Preventive care including well woman and well baby/child care is a standard in-network benefit.

The FlexCare product may be insured by Connecticut General Life Insurance Company or self-insured and administered by Connecticut General Life Insurance Company. The provider network is managed and administered by the local or associated healthplan.

FlexCare Dual Option Designated Provider Program (DPP)* - A FlexCare DPP Dual Option is similar to the previous product (Stand-alone DPP), with the exception of requiring employees to enroll once a year in either a CIGNA traditional group Indemnity plan or the DPP plan with opt-out privileges. Employees may not move back and forth between the two options at the point-of-service. The traditional group indemnity option is designed with benefit levels higher than those of the supplemental indemnity coverage attached to the DPP, but lower than those of the CHP network.

FlexCare Dual Option Exclusive Provider Program (Like an HMO)* - With this plan, once a year employees choose between two options. Option 1, which provides the most comprehensive levels of coverage, is the Exclusive Provider Program in which employees must receive all their non-emergency care within the CIGNA Healthplan (CHP) network of providers. Under option 2 they receive coverage under the traditional group medical indemnity plan at a reduced level of benefits. Preventive Care, which includes well woman care, is a standard benefit in Option 1; it is an optional benefit in Option 2.

Health Maintenance Organization (HMO)* - Under this plan, employees must receive all their care within the CIGNA Healthplan (CHP) network of providers. CIGNA Companies has established both staff model HMOs and Independent Practice Association (IPA) type HMOs. These plans standardly cover preventive care such as well woman care and routine physicals for children and adults.

HMO products are available from a local Healthplan company.

MENTAL HEALTH AND SUBSTANCE ABUSE PRODUCTS

CIGNA EAP - A CIGNA Employee Assistance Program can be an important first step in reducing costly mental health and substance abuse claims. Accessible via a 24 hour, toll-free number, local EAP counselors (part of a network of licensed psychologists and Master-level counselors) will provide assistance and early resolution for many problems, and refer employees or their family members to appropriate, cost effective providers if further treatment is needed. Benefit levels can be structured to provide the appropriate incentives for employees to access the EAP. The EAP can also be designed in combination with other managed care products.

*Not Available in Montana

Psychiatric Utilization Management - Because of the many methods of treating mental health and substance abuse problems, and the variety of practitioners, we developed the Psychiatric Utilization Management program to discourage inappropriate utilization without limiting an employee's choice of providers. Administered by Intracorp, CIGNA's medical review company, the program can be a carve-out to a regular medical indemnity plan and can include Outpatient Utilization Review, Inpatient Utilization Review, and Case Management Services. It is sold in conjunction with whatever mental health benefits the employer has chosen.

Specialized Mental Health and Substance Abuse Networks - To provide an even greater degree of control over mental health and substance abuse claim costs, we have developed specialized networks, administered by MCC Managed Behavioral Care, Inc., a CIGNA subsidiary and leading provider of mental health and substance abuse management programs. With this program, treatment is coordinated and care is delivered within a network of local mental health providers. The program is available in several versions:

- In conjunction with a CIGNA medical indemnity plan, on either:
 - a point-of-service choice basis, or
 - a network-only basis;
- as a stand-alone product; or
- as a standard part of CIGNA's managed medical networks (PPOs, FlexCare, HMOs).

Wellness Programs* - In order to meet the challenge of the continued rise in costs of medical care, our emphasis is on preventive health care. Our Staff model HMOs have formal wellness programs offered on-site at the various Health Care Centers for employees enrolled in a staff model HMO plan. The programs are free to the employees and are offered on a broad range of topics including: arthritis, asthma counseling, cardiac dietary counseling, cardiac risk factors, diabetes in pregnancy, cholesterol management, nutrition, prenatal education, smoking cessation, aging and stress, assertiveness training, medication safety, weight control and time management.

Our IPA HMO networks offer various types of wellness programs. Programs may be offered in response to specific client needs/requests within a given community. Preventive care, such as periodic physicals for adults, well-baby care, high risk pregnancy surveys, lamaze classes, smoking cessation, weight management, and routine immunizations and injections is stressed. Cholesterol screening and mammogram testing are also common features of wellness/preventive care programs.

CIGNA is currently studying the introduction of a program that would make these types of wellness programs available to our other Managed Care Medical customers.

*Not available in Montana

INTEGRATED SYSTEMS

Quality of Care

The following describes the selection criteria used by CIGNA for participating PPO and HMO providers in the state of Montana and throughout the country.

CIGNA recognized that the core of its health care delivery system is in its participating physicians. The viability of our system depends on attracting and retaining physicians who function as strong proponents of managed care. Our key features for selection of panel physicians are quality of care, efficient practice and satisfied patients.

The performance of CIGNA's physicians is evaluated regularly in accordance with these three objectives. It is the intent of CIGNA to select physicians who are able to support our managed care objectives, and meet our credential requirements and fit with our business strategy.

Quality Care

- A. A thorough understanding and acceptance of the role of the PPO network care physician.

We expect panel physicians to be comfortable in their role and to be able to function as an advocate and guide for their patients through the medical system.

- B. Demonstrated commitment and enthusiasm for the practice of medicine.

We expect physicians to maintain an active professional interest which is evidenced by continuing education activities.

- C. Satisfactory compliance with medical record standards.

Physicians, especially those providing primary care (and also a participant in an associated healthplan), must agree to allow CIGNA to review their medical records as part of our Quality Management Program. They must maintain records that are suitable for this purpose, i.e., legible, complete, and current.

Efficient Practice

The physician's practice style must be consistent with sound utilization management goals. It is desirable that they be comfortable with alternatives to hospitalization and that they use other specialists as consultants. They should also collaborate well with other specialists and other health professionals by providing pre-operative evaluations and concurrent hospital care for patients attended by surgeons and by supporting home health care through visiting nurses.

- A. The physician's office must be equipped to handle EKGs, drawing blood, immunizations and routine PAP and pelvis exams (except pediatric offices).
- B. The physician's office should not be equipped for excessive diagnostic or ancillary services.

Patient Satisfaction

Patient satisfaction is strongly influenced by how patients are treated. It is our intent to select physicians who are "service-oriented".

- A. The physician must provide adequate coverage and accessibility for patients. His/her office must be clean with a waiting area that can accommodate five patients per physician, two exam rooms per doctor, and an accessible bathroom. The office staff should be helpful and display a sense of caring for patients. There should be easy access to a clean, properly supplied bathroom.
- B. There should be adequate physician coverage and accessibility to participants. There should be appropriate arrangements for 24-hour on-call coverage for emergencies. There should be scheduled office hours at least 4 days per week. There should be routine appointment bookings of not more than five per hour (six per hour for pediatric offices).

CIGNA expects much of the information required to complete the selection process can be obtained through telephone interviews with the physician's office staff, prior to submission of an application.

CIGNA has established a corporate policy on standards for physician participation which specifies credential requirements. CIGNA has also established a network strategy that considers the desired number and locations of participating physicians. Our policy and strategy are the two components that influence physician selection. The guidelines listed below are a third. All three factors are necessary in considering physician candidates.

The following standards are used in the physician selection process:

- Signed application
- Signed agreement
- Copy of unrestricted state medical license
- Copy of current DEA registration
- Verification of hospital admitting privileges
- Board certification status
- Copy of current professional liability coverage and history

Hospital Selection Process

Hospitals are selected based on their reputation within the community (quality, efficiency, and cost effectiveness), full service capabilities, charges and negotiating stance, accreditation, medical staff and location in the service area. CIGNA applies similar criteria to home care contracting with great emphasis applied to clinical services; i.e., infusion therapies.

Hospital Selection Criteria:

- Geographic reputation
- Types of services
- JCAHO accreditation
- Favorable rate structure
- Desirability to key employers and employees
- Appearance and cleanliness of facility
- Utilization trends

Ancillary Section Process

Ancillary providers and services are selected based on their reputation within the community (quality, efficiency, and cost effectiveness), full service capabilities, charges and negotiating stance, ability to meet statutory requirements for ancillary specialties, fully licensed clinical staff, and location in the service area. CIGNA applies similar criteria to home care contracting with greater emphasis applied to clinical services and staff licensing; i.e., infusion therapies. The Ancillary Selection Criteria is as follows:

- Geographic reputation
- Types of services
- Appropriate licensing/regulation
- Favorable rate structure
- Desirability to key employers and employees
- Appearance and cleanliness of facility
- Utilization trends

Provider Quality

CIGNA's National Medical Department has a number of programs in place to ensure that our participants receive cost effective, quality health care. It begins with our Quality Management Policy Statement, which was established in 1982 and is reviewed and updated regularly. Each of our PPOs associated with a healthplan has a formal written program based on the Corporate Model, and modified to meet community needs. Each provider is evaluated based on his affiliation with an associated healthplan. This includes a Quality Management Committee made up of physicians from the local medical community. The Peer Review function is included in the responsibilities of this committee.

For PPOs in areas where CIGNA does not have a healthplan, nearby healthplans and community physicians are used on a consulting basis. The Quality Management Programs are based on the Corporate Model and can be monitored by local healthplan Medical Directors or Regional Medical Directors.

On an ongoing basis, CIGNA's Medical Directors and/or Regional Contracting Officers (Network Managers) monitor the physician's practice patterns, range of services and office operations. CIGNA regularly asks participants through telephone surveys about their satisfaction with their physicians. Physicians are routinely given the results of these surveys and use this information and analysis to provide better and more efficient health care services, as well as understanding how they perform compared to their peers.

Guidelines for appropriateness and quality of care are established using a Peer Task Force of physicians from various specialties who review the current literature and technology and who also review the standards set by a number of professional organizations such as the American College of OB/GYN, American College of Surgery, etc.

Precertification and continued stay review, components of Utilization Review, monitor quality and appropriateness of services and utilization. Case management, also a component of Utilization Review, assures that participants receive quality care in the most appropriate setting. Utilization Review also tracks medical costs and utilization.

CIGNA's goal is to facilitate utilization management and quality of care by providing physicians with education, training, and feedback that ensures the best care at the lowest cost.

The PPO providers in Vermont will be re-credentialed on a bi-annual basis. Patient satisfaction results are routinely reported to the physician. If the network receives a complaint, this information is transmitted to the appropriate officials of the network who have authority to take corrective action. A local of Regional Medical Director may be used for quality and performance issues. The specific problem areas are reviewed with the intention of modifying the physician behavior through education and training.

In Montana, where CIGNA does not have an HMO, physician monitoring and evaluation are conducted in several ways. The first is by Intracorp, who will be doing the Utilization Review. Any performance standards related to Utilization Review will be assessed by Intracorp (using Corporate standards), including physician practice pattern review.

QUALITY IMPROVEMENT AND ASSURANCE

In PPO locations where we do not have an HMO, such as Montana, quality of care issues are handled through Intracorp and the PPO Contracting Offices (Network Manager).

Retrospective review, including physician practice pattern record review will be introduced as measurement instruments in 1994.

The purpose of CIGNA's quality management program for each of its PPO sites is to measure, monitor and enhance the quality of CIGNA's health care delivery system for our customers. Objectives of the quality management program are to:

- ◆ Deliver effective health care. This particular objective is best accomplished through assessing and reviewing the outcomes of care delivered;
- ◆ Provide ongoing monitoring and evaluation of the care provided. This objective is accomplished through establishing a generic screening process (for example, occurrence screens, quality of care indicators, etc.);
- ◆ Pursue opportunities to improve health care. This is best accomplished through support for industry efforts to develop concrete mechanisms to measure quality outcomes. As you know, the health care industry lacks any universally acceptable quality measurement tools. CIGNA has recently become a participant of the policy advising committee of the Rand Quality of Care Consortium.
- ◆ Pursue identified areas for quality improvement. This particular objective is accomplished by reassessing actual practices to determine that the desired results have been achieved and sustained;
- ◆ Meet applicable governing agencies' requirements. CIGNA networks maintain state, federal and any external accrediting agency requirements.

The key principles of CIGNA's quality management program mean that:

- Participants come from a variety of disciplines.
- All patients stand an equal chance that their care is reviewed.
- The program seeks participant/provider feedback.
- There is corrective action from involved people and systems.
- Program effectiveness is evaluated annually.

The CIGNA health care quality management program has three major components:

- ◆ Quality Management Committee
- ◆ Peer Review Committee(s)
- ◆ Quality Measurement Studies

The first of these components, Quality Management Committee, provides oversight for the quality management program, coordinating all quality management activities, both medical and non-medical. The Quality Management Committee is accountable through the Executive Director of an associated healthplan/PPO Site Management to the CIGNA Healthplan/network board and ensures that the quality management functions are consolidated, integrated and coordinated. The medical director of the associated healthplan has day-to-day, overall responsibility for all quality management activities. The membership of the committee consists of a healthplan executive director/ppo Site Manager, an associated healthplan medical director, two or more participating CIGNA network physicians (depending on the size of the site), quality and utilization management coordinators and any others so designed. (PPO/Network personnel)

The second component, Peer Review Committee(s), advise and assist the associated healthplan medical director in evaluating individual physicians and health care providers, confirm standard for medical reviews, as well as analyze results and recommend actions as appropriate. participant of the Peer Review Committee are either CIGNA participating physicians or other physicians as determined by a healthplan medical director/PPO Site Management.

The third and final component, Quality Measurement Studies, is a vital component reflecting the actual performance of the providers in our health care network. There are many different types of studies that can be pursued in the quality improvement process. We try to focus attention on studies that:

- Provide information leading to substantive behavior modification, those that allow us to provide helpful feedback to the providers;
- Ensure timeliness and cost effectiveness;
- Improve the system of providing care to participants;
- Significantly impact healthcare quality, i.e., high volume, high risk, problem prone areas.

Effective quality measurement methods are those that can be systematically applied to provide quantified results. They must also be credible, particularly to physicians in the community. CIGNA, recognizing the need for a generally acceptable quality measurement methodology, continues to seek better understanding in execution of quality controlled activities through involvement with leading edge research on the measurement of medical quality throughout our system. Currently, CIGNA is introducing the application of quality measurement in the form of surveys, outcomes and reviews.

Surveys collect and analyze the opinions of people who have interacted with the health care system. This may either be the patients or providers.

Outcomes are observed events. Adverse events are one type of outcome. Once an adverse event has occurred it obviously cannot be prevented. However, measurement of such activity may provide a basis for development of preventive strategy.

Reviews are of medical records, used to determine compliance with medical guidelines. Medical guidelines specify the technical process of evaluating and treating a clinical condition. The limiting factor in establishing current medical guidelines is obtaining the physician consensus necessary for credibility.

To be more specific, CIGNA is introducing a quality measurement instrument in each of the three areas throughout our networks.

Survey Method

Panel of physician who provide primary care to 100 or more participants will be surveyed to determine patient satisfaction. The survey seeks the patient's impression regarding the courtesy, communication skills and perceived knowledge base of the physician. The instrument is statistically sound, provides quantified results and obtains credibility by comparing physician results on a rank order basis.

Outcome Method

CIGNA has established a list of specified, adverse events and sentinel diagnoses, such as unplanned readmission within 30 days for the same body system. We will identify all such events and will input them into an automated system. Adverse events and sentinel diagnosis are reviewed by the associated healthplan medical director who may initiate a peer review or risk management investigation as deemed appropriate.

Contracting With Quality Effective Providers

For initial network setup, CIGNA uses a combination of our Corporate Network Development Department, Provider Relations Representatives at local healthplan sites, PPO Network Managers/Regional Contracting Officers and their staff, and outside consultants for recruitment of providers. There is a training program and manual utilized in the recruitment process, as well as follow-up procedures.

When the network is fully operational, Provider Relations Representatives from associated healthplans and PPO Network Managers/Regional Contracting Officers and their staff will recruit providers.

The first step is to identify hospitals for possible participation. Once a PPO site has been targeted and a hospital recruitment listing has been established, a proposed hospital reimbursement schedule is established. An actuarial analysis is done to determine a reimbursement arrangement that is financially beneficial and competitive in the Montana marketplace.

At this juncture, the Network Manager will send the proposed reimbursement arrangements to Claim for its sign-off and to be sure the reimbursement schedule conforms to automation guidelines.

Once hospital negotiations are under way, the physician recruitment process begins. The Healthplan obtains a list of physicians who are affiliated with the targeted hospitals and who have admitting privileges to the hospital. Since there are no primary care physicians and hence no capitation, a fee-for-service schedule will be the basis for the PPO fee schedule.

The Network Manager/Regional Contracting Officer will coordinate reviewing the physician fee schedule with Claim in order to determine whether it can be automated. This automation is the degree to which Medicom and CIGNA Claims, our claim payment systems, can automatically calculate the allowable amount, given a particular fee schedule.

ALTERNATE MECHANISMS FOR PAYMENT TO PROVIDERS

Physicians

CIGNA prefers to reimburse physicians on a discounted fee-for-services or maximum allowable fee schedule.

Hospitals and Other Institutions

CIGNA prefers a per diem arrangement with hospitals. Accordingly, this reimbursement method dominates CIGNA's networks. However, due to certain marketplace attitudes and regulatory issues, CIGNA has agreed to other forms of reimbursement including DRGs and discounted fee-for-service arrangements.

For ancillary services such as mental health, and laboratory services, CIGNA's preferred method of reimbursement is discounted fee-for-service; this includes discounts off billed charges.

The fee structure is negotiated at the point of recruitment; fee structure is renegotiated annually.

UTILIZATION MANAGEMENT

CIGNA's Utilization Management Program addresses all areas where medical management can impact and facilitate the appropriate utilization of services. Program functions are designed to:

- ◆ Provide preauthorization of all non-emergency hospital admissions and surgical procedures according to written standards for appropriateness of procedure and setting;
- ◆ Concurrently monitor all hospital inpatient care and select those hospital cases for on-site review and for prompt discharge planning that are likely to yield benefits from such additional efforts; and
- ◆ Coordinate and monitor the treatment plans for chronic or catastrophic cases which have been identified for case management (if purchases by the policyholder).

This purpose is accomplished through an on-going, formalized system of reviews which incorporate concurrent, retrospective and prospective methodologies.

Connecticut General Life Insurance Company contracts with vendors for utilization management services. These vendors are Intracorp, MCC Behavioral Care and sometimes CIGNA Health Plan.

ADMINISTRATIVE METHODS

CIGNA is moving toward a standard electronic environment advocated through WEDI (Workgroup on Electronic Data Interface) and ANSI standards. CIGNA is a member of the Connecticut EDI Project which is looking to adopt electronic standard formats for enrollment, eligibility, claims submission, and payment and remittance advice. Although this effort applies to Connecticut, it is intended to be a model for the country. CIGNA currently supports electronic claim submission through NEIC and is looking to have electronic remittance advice in place shortly.

CIGNA accepts standardized claim formats as well as common coding schemes (i.e., CPT, HCFA Common Procedure Coding System, National Drug Codes, ICD-9-CM, DSM-III-R, ADA Dental Procedure Codes, and Revenue Center Codes).

Internal performance standards are in place including time to process and quality and accuracy of claim payments.

THIRD PARTY LIABILITY/COORDINATION OF BENEFITS

When a claim is submitted, the benefit analyst carefully examines the claim form to determine if other coverage is indicated. When other coverage is indicated, the benefit analyst is responsible for determining the appropriate carrier for both primary and secondary coverage. We will contact the other carrier, if CIGNA is the secondary carrier for the claim, for the necessary payment documentation.

The success of a COB provision depends to a large degree on our ability to identify employees covered under other group plans. While we rely on the claim form as the primary source for this information, we would also investigate COB possibilities when:

- Our medical or dental claim system, editing against eligibility and prior claim information, identifies the existence of other coverage in history.
- A hospital or provider's bill makes reference to other coverage.
- The hospital or provider's bill shows a substantial credit or adjustment to the account.
- The claim presented is for the spouse of an employee.
- The claim presented is a maternity claim and the first claim for a dependent wife. There is a possibility that the spouse had been regularly employed until her pregnancy, and benefits may be available through the extension of benefit provision of the spouse's plan.
- The claim documents are presented in the form of photocopy or otherwise duplicated bills.
- There is a charge for completion of the form. No charge is made for the completion of the first hospital claim form, but there are charges for subsequent forms.
- The documents submitted include another carrier's claim forms.
- We receive a Duplicate Coverage inquiry from another carrier.

ANTI-FRAUD

CIGNA maintains a separate unit to analyze and investigate potential fraud. Fraud is broken into two categories: internal fraud and external fraud.

For internal fraud, a routine review of payment activity printouts is the primary source for the detection of computer assisted fraud by one of our own employees. The Fraud Unit looks for certain fraud indicators signaling the need for further investigation. Such indicators include confirming with the providers that the services and fees identified are correct. In addition, CIGNA's Internal Security division periodically asks for payment confirmation from claimants on selected claims.

In a situation involving a potential external fraud, one of our first lines of defense is the benefit analyst. Analysts are trained to be aware of fraud indicators such as altered claim forms and inappropriate use of terminology. When a suspicious billing is identified, we will flag specific providers for further investigation. In addition, the Home Office Fraud Unit may also identify this type of fraud in their review of payment activity printouts. This review process involves the selection of certain claims for additional investigation.

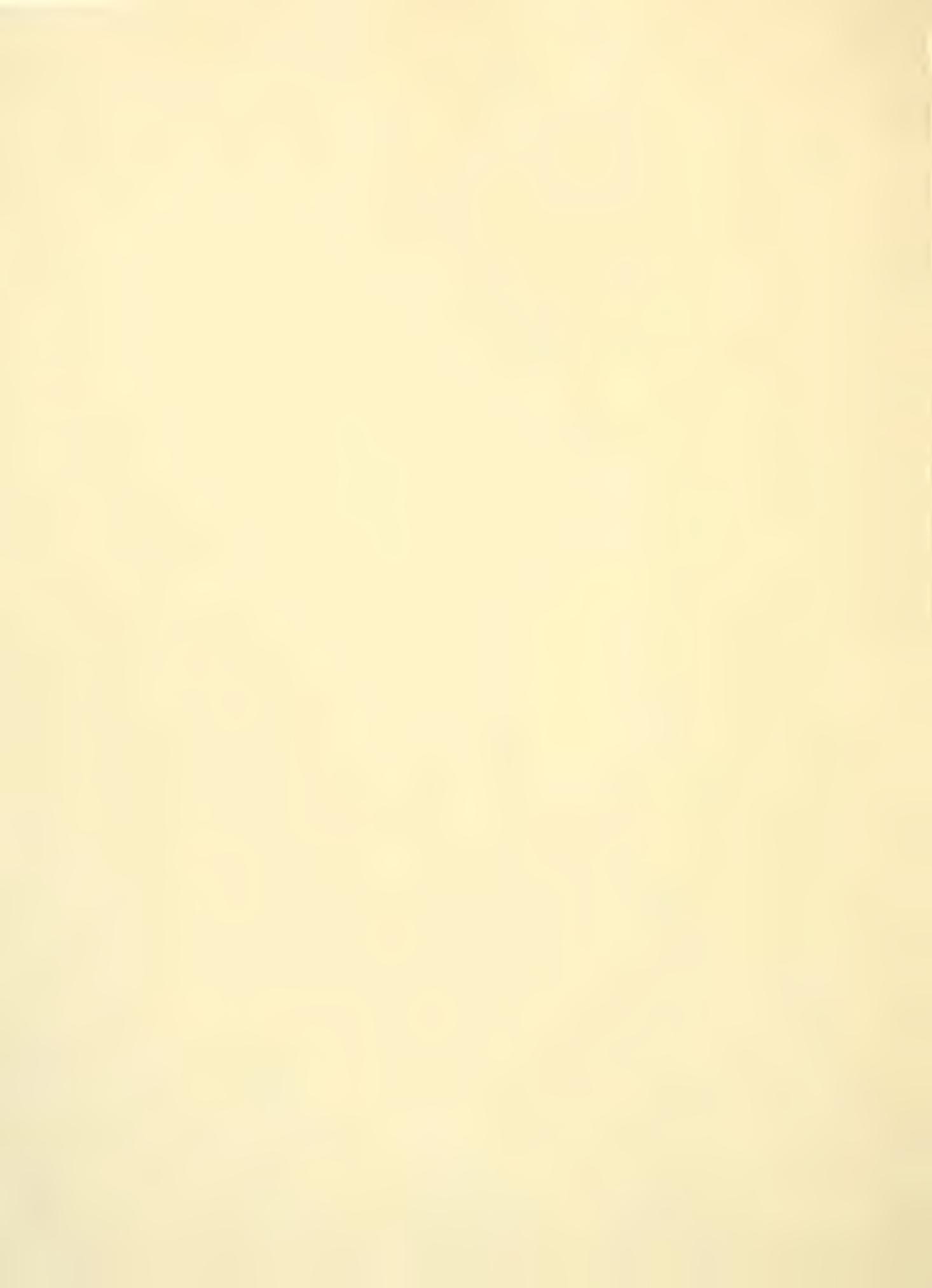
Documented evidence on a confirmed case of fraudulent claim submission is shared with the policyholder. CIGNA and the policyholder determine the course of action to be taken. Once the information has been developed to support a case fraud against one of our employees, the employee is immediately terminated and prosecution is sought by referring the evidence to the appropriate law enforcement personnel. In the case of provider fraud, the substantiated evidence is referred to a law enforcement agency or the State Insurance Fraud Bureau.

THE CIGNA MANAGED CARE CONTINUUM

LEAST COST CONTROL						MOST COST CONTROL	
TYPE OF PLAN	INDEMNITY	INDEMNITY WITH UTILIZATION REVIEW	PREFERRED PROVIDER ORGANIZATION (PPO)	GATEKEEPER PPO "FLEXCARE"	HEALTH MAINTENANCE ORGANIZATION - IPA	HEALTH MAINTENANCE ORGANIZATION - STAFF	
SERVICE	Access to any physician and hospital	Access to any physician; pre-approved access to hospitalized care and selected outpatient procedures	Incentive to access specific network of physicians and hospitals; freedom to select out-of-network physicians/hospitals but at a higher employee cost.	Access to specific network of physicians and hospitals with freedom to select out-of-network services at point-of-service, but at a higher employee cost.	Access to specific network of physicians and hospitals.	Access to specific health center physicians and contracted hospitals.	
COST CONTROL FEATURES	Review of fraudulent claims;	Review of fraudulent claims; manages unnecessary surgery and hospitalization	Discounted hospital and physicians' fees.	Primary care physicians and healthplan utilization of all health-care services; hospital and physicians' fees at a discount; point-of-service choice improves employee enrollment.	Primary care physicians and healthplan utilization of all health-care services; hospital and physicians' fees at a discount.	Salaried staff physicians/ specialists manage utilization of services,	
ANNUAL COST TO EMPLOYER	22%	24%	21%	16%	13%	10%	
SERVICE ADVANTAGES TO PATIENT	Access to any physician and hospital.	Access to any physician, access to any hospital after prior approval.	Lower costs of services obtained in-network.	Access to any physician and hospital, but at a higher cost if out-of-network; member service assistance; preventive care; low copayments in-network.	Low copayments; no claim forms; member services assistance; preventive care covered.	Low copayments; no claim forms; member services assistance; preventive care covered.	
SERVICE DISADVANTAGE TO PATIENT	Out-of-pocket expenses vary; claim forms to file.	Additional process and paperwork for providers.	Must use approved list of contracted physicians and hospitals to obtain higher reimbursement.	Greater cost when accessing non-network providers.	Must use approved list of contracted physicians and hospitals.	Must use center physicians/ specialists.	
MONTHLY EMPLOYER PREMIUM**	\$382	\$371	\$366	\$354	\$325	\$292	

*Averages as of fourth quarter 1992; rates vary depending on local market conditions and are subject to change.

**CIGNA's monthly premium as of fourth quarter 1992, based on an average charge for employee/family coverage around the U.S.





CONTINENTAL

Life & Accident Company®

101 South Capitol Boulevard
P.O. Box 2640
Boise, Idaho 83701-2640
(208) 387-2100
(208) 345-1267 (Fax)

April 18, 1994

Mr. Mike Craig
Montana Health Care Authority
28 N. Last Chance Gulch
P. O. Box 200901
Helena, Montana 59620-0901

RE: Cost Management Plan

Dear Mr. Craig:

Thank you for your assistance in completing our Cost Management Plan.

Please find enclosed our most current information regarding our Cost Management Plan including a completed data sheet.

If you have any questions or need additional information, please contact me at 800/759-7007, extension 2103. Thank you.

Sincerely,

**CONTINENTAL LIFE & ACCIDENT
COMPANY**

Carol Sola^{a/c}

Carol A. Sola
Compliance Analyst

*CAS.lgm
Enclosure*

National Group Life

April 18, 1994

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Montana Health Care Authority
28 N. Last Chance Gulch
P. O. Box 200901
Helena, Montana 59620-0901

RE: Cost Management Plan

Dear Mr. Craig:

Thank you for your assistance in completing our Cost Management Plan.

Please find enclosed our most current information regarding our Cost Management Plan including a completed data sheet.

If you have any questions or need additional information, please contact me at 800/759-7007, extension 2104. Thank you.

Sincerely,

NATIONAL GROUP LIFE INSURANCE
COMPANY

Carol Sola ^{al}

Carol A. Sola
Compliance Analyst

CAS.lgm
Enclosure

National Group Life Insurance Company
Chicago, Illinois
Executive Office: 304 North Main Street
Rockford, Illinois 61101
(815) 987-5000

AREA ONE:***INTEGRATED SYSTEMS FOR HEALTH CARE:***

We provide benefit packages that include discounts to encourage healthy lifestyles, and flexible benefit plans that provide the most cost-effective services to meet a patient's needs. These include: mammography benefit, mental health/substance abuse treatment, well child care, and special riders that can be included with coverage at an additional premium.

We utilize provider networks that have been developed based on utilization, quality profiling, and patient satisfaction, such as America's Health Plan, which in turn has promoted cost effectiveness.

**AREA THREE:** ***UTILIZATION MANAGEMENT:***

National Health Services (NHS) provides precertification for hospital confinements, surgical procedure and same-day surgery.

We apply case management as a means of achieving wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. Our case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source.

Alternate care is care rendered in lieu of inpatient, acute care, or hospital confinement. This is a systematic approach to coordinate/arrange the most appropriate setting for a patient's treatment that safely meets the patient's medical needs in a cost-effective manner that helps to provide optimum outcomes for the patient. Alternate Care deals with extra-contractual agreements that are then forwarded to NHS and eventually submitted, case by case, to the panel for a decision on extra-contractual benefits.

AREA FOUR: ***ALTERNATIVE MECHANISMS FOR PAYMENT TO PROVIDERS***

America's Health Plan is the primary PPO network for the state of Montana. This cost containment measure is a form of health care delivery in which a group of health providers (physicians and hospitals) agrees to supply services to a defined group of patients at an agreed-upon fee for service rate.

If the provider is not a member of the PPO network, we will attempt to negotiate a savings through DHI negotiation or Select Plus.

Prompt Associates/Genesis evaluates same-day surgery facility charges for repricing (usual and customary fees), and provides us with the details of the savings.

Medical Data Research (MDR) is the medical UCR payment system that is a national database of prevailing fees and is referenced by zip code and medical procedure code. It includes prevailing charge data arrayed in eight percentiles for over 93% of all Currently Used Procedure (CPT) codes in surgical, medical, radiology and laboratory procedures.

GMIS is a form of cost containment used to evaluate multiple surgical procedures. This process is used to determine which surgical procedures were unbundled by the provider, and which were incidental to a more primary procedure.

Preferred Payment Systems (PPS) provides negotiation on physician expenses. PPS provides an increase in actual dollars saved by negotiating discounts. PPS also provides an increase in productivity by minimizing requests for reconsideration of usual and customary reductions.

When relevant to the policy, we do have deductible reductions upon the use of a PPO facility for a hospital stay or, in some cases, for same-day surgery. In addition, if the hospital stay or same-day surgery is pre-certified as outlined by the contract, we will also reduce the deductible by a specified percentage. This procedure has been implemented to encourage pre-certification and the use of PPO facilities.

AREA FIVE:

THIRD PARTY LIABILITY/COORDINATION OF BENEFITS:

We do have policy contract that include a subrogation rights provision which, in the event of any payment under the policy, we will, to the extent of the payment, be subrogated to all rights of recovery arising out of the acts or omissions of any person or organization.

Some policy contracts contain a Right of Recovery Provision which states, respectively, that whenever payments have been made by us in excess of the maximum amount necessary at that time to satisfy the intent of this provision, we will have the right to recover such payments to the extent of such excess from any person such payments were made; any other insurance company; or any other organization.

We presently utilize the services of Health Cost Control (HCC), J.W. Hutton, and Subro Audit for recovery. We maintain individual records for all companies along with the cost of the recovery and the actual amount of recovery. Recovery range is from 66% to 100% reimbursement rate.

Lastly, all group contracts contain a Coordination With Other Benefit Plans provision. All the health insurance benefits provided under the group policy are subject to this provision for coordination of benefits.

AREA SIX: ***ADMINISTRATIVE METHODS:***

Our cost management includes acceptance of standardized claims' formats, collection of information to support a unified database, acceptance of common coding schedules, procedures to conduct internal performance monitoring, and measurable claims processing performance standards.

AREA SEVEN: ***ANTI-FRAUD EFFORTS:***

We are currently pursuing investigate methods to prevent and detect fraud and abuse. We have a consumer watch program which organizes the efforts of the insured and our company to eliminate billing errors. This program encourages our insured to review medical bills very carefully. We ask that the insured send us a copy of the bill with the charges in question circled, and also a completed consumer watch program form. We handle all of the investigation. If we find that the charges were billed in error, we forward a check to our insured for 25% of the savings realized, up to a \$1,000.00 maximum.

We also utilize the services of Medical Review Institute of America for physician examination for over-utilization (excessive visits and unnecessary testing), and abuse and fraud (muscoded procedures and services not rendered).

The professional opinions are rendered by board certified physician specialists and other practitioners who do peer reviews in over 50 medical specialty areas. Medical Review Institute of America has no ties whatsoever with any medical association or organization, local or national, which assures a higher level of credibility for every claim review.

Cost Management Plan
for
Montana Health Care Authority
March, 1994

**Continental Life Insurance Company
714 Main Street
Fort Worth, Texas 76102**

Topic/Area Six: **Administrative Method**

37. Procedures to conduct internal performance monitoring.

- ① Installed service matrix and ongoing measurement to track performance on basis of accuracy of claim payment (amount, coding and communication), timeliness of processing, and productivity on a per-examiner, unit and department basis. Service matrix developed in 1991, with continued review and revision to improve service and productivity results.
- ① Review administrative costs on a monthly basis. Have analyzed and developed a cost-per-claim index by product line; changes are monitored on monthly basis, with investigation and necessary corrective action resulting.
- ① Developed online mail and phone call logging systems which enable us to monitor communication from insureds and providers. Extensive tracking mechanisms flag us on outstanding aged items or claims with repetitive situations that would indicate that additional communication for clarification is needed.

33. Acceptance of standardized claims formats

- ① We accept all standardized claim formats submitted to us.

36. Workgroup on Electronic Data Interface (WEDI)

- ① We are analyzing the effectiveness and impact of adopting the WEDI or other electronic standardized formats. Part of the consideration will be the appropriateness of this technology for our predominantly supplemental and indemnity products.

34. Collection of information to support a unified database

- ① We will consider coding or formatting changes that will improve our productivity and effectiveness with our customers and providers.

35. Acceptance of common coding schemes

- ① We accept the following coding schemes:
- CPT -HCFA -NDCs -ICD -ADA codes

We have had no claims submitted with NDCs or Revenue Center codes.

38. Other administrative management strategies

- ① Have implemented a work management system, with ability to identify through the combination of specific work assignments and mail control tags the status of all pending and in-process claim activity.

Topic/Area Seven: Anti-Fraud

39. Fraud and abuse controls

- ① Established training on claim fraud and claim abuse detection and processing. All claim examiners receive training upon hire and have an annual refresher course. Seminars on specific abuse/fraud topics are presented as we have a situational need or as we become aware of fraud/abuse patterns through industry associations.
- ① Our Special Investigations Unit (SIU) was established over a year ago. All claims with a potential for abuse/fraud are referred to this unit for analysis by our SIU Analysts. A determination is made as to what investigational activity will be done on a case-by-case basis.
- ① We have been using the services of a major claim abuse/overpayment automated review systems. A system copy of our entire claim file is sent on a monthly basis and run through the program that compare our claim data to a large number of heuristics. Variance from typical care-to-diagnosis, R&C, and a host of other conditions flag those claims on an automated basis for review and potential investigation on a manual basis.
- ① Claim forms have been modified to include a standard statement on claim fraud that informs that knowing and willing intent to defraud or deceive on a claim filing is a felony and that we will actively pursue such action.
- ① We are in the process of modifying our Explanation of Benefits form to add a toll-free number for claimants to report benefits paid for services they did not receive.

40. Other innovative strategies

- ① Under consideration is membership in a database referral system that allows automated access to query on suspect claims. This would assist in the evaluation of our investigational needs and be part of an effective cost/benefit consideration in the control of investigation costs..

Topic/Area Four: Alternative Mechanisms for Payment to Providers

22. Payment mechanisms for hospitals.

- ① Contact hospitals for all billings in excess of \$10,000 to negotiate discounts.
- ① During claim adjudication process, address situations where "unbundling" or "bundling" of charges would result in reduced costs.
- ① During monthly automated claim review process, identify any "bundling" or "unbundling" optimization situations that were overlooked during manual process; contact hospital to receive credit.

23. Payment mechanisms for providers

24. Payment for outpatient hospital services

- ① During claim adjudication process, address situations where "unbundling" or "bundling" of charges would result in reduced costs.
- ① During monthly automated claim review process, identify any "bundling" or "bundling" optimization situations that were overlooked during manual process. Contact to receive credit.

25. Payment mechanisms to encourage bulk purchasing.

26. Payment mechanisms to encourage quality improvement capacities of providers.

27. Other strategies in payment mechanisms

Strategies 25, 26 and 27 are not directly applicable to the products for which we administer claims.

Area/Topic Three: Utilization Management

17. Pre-and Post-Payment Claims Review

- ① During the claim adjudication process, the trained examiner reviews the charges to ensure claims are paid within the pre-defined contractual limits. System edits in the claim processing system pend any claims processed that exceeds pre-set limits and requires a supervisory review.
- ① During monthly automated claim review process, any charges in excess of local and/or regional usual and customary are flagged. This prompts a manual review and analysis to determine if overpayment credit will be sought or whether we have additional investigation to determine a potential claim abuse or fraud situation.

18. Internal Retrospective Review of accuracy of care provider decisions.
19. Drug Utilization Review to determine the accuracy/appropriateness of prescription medications.
20. Utilization Management Tracking to determine if strategies are effective and should be continued or modified.
 - ① All claim examiners are trained on the typical care treatments for the specified disease and more comprehensive health products. On a case-by-case basis any questions as to appropriateness of care, care strategies or prescription drugs for the condition diagnosed is referred to an independent assessment firm comprised of physicians with medical specialties.

21. Innovative strategies in utilization management.

- ① We consider and implement any utilization management strategies appropriate to the health insurance contracts for which we administer claims.

12. Case Management

14. Concurrent Review to determine appropriateness of continued stay.

15. Discharge Planning

16. Outpatient Utilization Review

- ① No specific case management is done for the individual specific disease policies. Our current senior age market product, which combines Long Term Care benefits as well as Home Health Care Benefits utilizes an Alternate Plan of Care. Under this feature we work with those insureds, their families and care providers to develop a cost effective plan of treatment appropriate to their care needs without confinement to a skilled nursing facility.

13. Pre-admission and admission review to hospital to determine appropriateness of admissions.

- ① Pre-admission/pre-certification is not required under our current individual specific disease products.

11. Provider profiling to determine utilization trends and service delivery patterns.

This strategy is not applicable for the products for which we administer claims.

Topic/Area Two: Quality Improvement and Assessment Strategies

10. Other innovative strategies in quality improvement and assessments.

- ① We have entered into a collaborative relationship with National Case Management Partnership. Their assessments, especially of the senior age segment of our customer population, seek to include many community-based and family-based services which reduce the overall cost of care while providing an improved social support system for our insureds.

6. Other innovative strategies for integrated health care delivery systems.
7. Contracting with providers with quality improvement and assessment in place.
8. Collection of data on efficiency, quality and patient demographics.
9. Use of provider profiling results in development of quality improvement and assessment features.

Strategies 6, 7, 8 and 9 are not directly applicable to the products for which we administer claims.

Topic/Area One: Integrated Systems for Health Care Delivery.

3. Flexible benefit plans that provide the most cost-effective services to meet patient's needs.
 - ⌚ Currently marketed senior-age products provide flexibility to utilize care at the level most appropriate to the need of the patient/insured. Specific disease policies by their nature do not have this flexibility.
4. Provider networks developed based on utilization, quality profiling and patient satisfaction.
5. Provider networks that promote cost-effectiveness.

Strategies 4 and 5 are not applicable to our Individual specific disease contracts.

1. Benefits packages that promote coordinated care.
2. Benefits packages that include health promotion and promote health education.

Strategies 1 and 2 are not directly applicable to the individual specific disease products currently marketed. However, new product design will consider appropriate incentives for health promotion to determine the effectiveness of these strategies as an overall cost management strategy.

Topic/Area Five: Third Party Liability/Coordination

31. Coordination of benefits

Coordination of Benefits is not a feature applicable to our Individual specific disease contracts.

28. Data matches to other organizations and insurers.
29. Cost avoidance processing through review of external databases.
30. Calculation of average savings to cost ratios to determine cost-effectiveness of TPL/COB activities.
32. Other innovative strategies in other party liability.

Strategies 28, 29, 30 and 32 are not applicable to the product mix for which claims are administered.

**EMPLOYERS HEALTH
INSURANCE**

1100 Employers Blvd.
Green Bay, WI 54344
800-558-4444

March 7, 1994

8

**Ms. Dorothy Bradley
Montana Health Care Authority
28 N. Last Chance Gulch
Helena, Montana 59620-0901**

**RE: COST MANAGEMENT PLAN for EMPLOYERS HEALTH INSURANCE COMPANY
and LINCOLN NATIONAL LIFE INSURANCE COMPANY (Administered by
Employers Health Insurance Company)**

Dear Ms. Bradley:

Enclosed is our cost management plan and completed data sheets. This submission should be documented on file for our affiliate, Lincoln National Life Insurance Company, as well, as we administer their group health business. Please note that we consider some of this material to be proprietary in nature and have therefore attached a disclaimer. This submission is organized according to the topics outlined in your published guidelines.

If you have any questions concerning this submission, please contact me at (414) 337-7023.

Sincerely,

EMPLOYERS HEALTH INSURANCE COMPANY

Susan E. Burger

**Susan E. Burger
Compliance Specialist**

enclosures

COST MANAGEMENT PLAN
for
EMPLOYERS HEALTH INSURANCE COMPANY
and
LINCOLN NATIONAL LIFE INSURANCE COMPANY

Topic/Area Six: Administrative Methods

(Item #36) About 15% of the claims in which we process are now received electronically from a service bureau which optically scans the claims. We are currently working to become independent of the scanning bureau by installing our own scanner. Our initial focus will be on scanning the HCFA claim forms, however we have plans to scan all other standard claim forms within six months.

Another 5% of the claims come from Electronic Data Interchange (EDI) clearinghouses which receive the information directly from the provider via computer.

We have found that 10% of the scanned claims pass through our computer system (as they include all necessary information and pass all system edits) automatically with an explanation of benefits and/or check issued and no further human intervention. EDI claims have a slightly higher percentage because their clearinghouse checks the claims before submitting them to us.

(Item #34) Our computerized claims processing system stores all provider IRS (Internal Revenue Service) numbers as these are used for identification purposes and are maintained in a data base. Furthermore, our system utilizes the employee's social security number for identification purposes.

Our provider and insured explanation of benefits are in separate formats, however there is no variance according to product or product line. We have recently revised the format of these two forms to match the prescribed versions according to Wisconsin law.

Topic 6

page 2

Our computer system is based upon common local coding requirements (CPT codes) and does accept local field indicators from the UB-82 and UB-92 forms.

Furthermore, our system automatically edits/audits claims to validate procedure and diagnosis codes. If claims are missing any information, contain incorrect provider data or unacceptable ICD-9 codes, the processing system then requires manual intervention.

(Item #35) Our computerized claims processing system currently accepts the following coding schemes:

1. ICD-9 (International Classification of Diseases) Procedure and Diagnosis codes;
2. CPT-4 (Common Procedural Terminology) codes;
3. HCPCS (Health Care Financing Administration's Common Procedure Coding System) codes;
4. UB-82 Revenue codes; and
5. ADA (American Dental Association) codes.

(Item #33) We do not require claims to be submitted on a specified form or in a specified format, as long as it is itemized, includes a diagnosis and the date of service. We presently accept all standardized claim formats as long as the necessary information is completed.

COST MANAGEMENT PLAN
for
EMPLOYERS HEALTH INSURANCE COMPANY
and
LINCOLN NATIONAL LIFE INSURANCE COMPANY

Topic/Area Seven: Fraud

(Item #39) Attached is an overview of our Anti-Fraud Plan. In order to increase awareness of fraud, all of our insured explanation of benefits contain the following statement:

"Please review this statement to assure that there are no discrepancies or irregularities between this and the treatment you obtained. You may notify us by using our toll free number 1-800-822-6275. Thank you for your efforts in containing health care costs."

All of our provider explanation of benefits (check remittance forms) contain the following statement:

"Help stop insurance fraud...If you know or suspect any illegal activity concerning insurance claims, please notify our anti-fraud unit using our toll free number: 1-800-822-6275. You do not need to identify yourself."

EMPLOYERS HEALTH INSURANCE

ANTI-FRAUD PLAN

The detection and prevention of insurance fraud is essential to maintaining a health care system that is affordable for everyone. Because premiums are calculated on claims experience, the victim of insurance fraud is, in fact, the policyholder.

In an effort to assure proper business practices and preserve reasonable premium rates, Employers Health Insurance aggressively investigates and pursues prosecution of health care insurance fraud by providers, insureds, agents, company employees and other individuals.

We are actively involved with anti-fraud organizations, such as the National Health Care Anti-Fraud Association of which we are a founding member. We also cooperate with federal, state and local authorities whenever possible.

Some of the actions taken by our anti-fraud unit are:

1. Recommendation to terminate agents' contracts with our company.
2. Termination of insureds' coverage.
3. Recommendation of criminal or civil litigation.
4. Restitution
5. Assist in the suspension or revocation of providers' licenses.
6. Denial of claims

We are actively involved in education and awareness programs for our employees, our insureds and the general public concerning health care fraud.

PREVENTION OF FRAUD BY EMPLOYEES

Cases of suspected employee fraud are reported to the Human Resources Department for investigation. Various procedures and system checks are in place to reduce the temptation for fraud including:

1. Claims are not processed and the check issued by the same person.
2. Different persons enter the claims into the computer system and process the claims for payment.
3. Checks must be issued to valid providers listed in the system with a tax identification number, or to the insured upon verification that payment has been made.

PREVENTION OF FRAUD BY AGENTS

Definition:

Deception, misrepresentation, or concealment by a licensed representative in order to obtain something of value for which he would not otherwise be entitled.

Examples of agent fraud:

1. Helping individuals fill out their enrollment cards so they will be eligible for insurance.
2. Enrolling a group of individuals to form a non-existent company.
3. Falsifying location of group to gain insurance or obtain lower premium rates.
4. Adding false individuals to the group to avoid being medically underwritten.

Special Investigations Unit procedures upon receipt of referral of suspected agent fraud:

- A. Determine if agent is actually involved
 1. Obtain information from insured/company
 2. Contact our sales office
- B. Determine if investigation is needed
 1. No investigation needed, document and close case
 2. Investigation needed
 - a. Obtain agent activity report from underwriter
 - b. Obtain written documents from agent/insured/company
 - c. Determine action needed
 1. No action needed, document and close case
 2. Recommend termination of agent's contract
 - d. Refer to legal to recover from errors and omissions carrier
 - e. Document in tracking system

- f. Report to appropriate law enforcement authorities and the Maryland Insurance Commissioner

PREVENTION OF FRAUD DUE TO
MISREPRESENTATION ON APPLICATIONS

Definition:

Commission of an act of deception, misrepresentation, or concealment, or allowing it to be done by someone else, in order to obtain coverage for which one would not otherwise be entitled.

Examples of eligibility fraud:

1. Several individuals joining together to form a non-existent group for insurance purposes.
2. Employee not meeting the eligibility requirements, i.e., not working required number of hours, not receiving earnings, etc.
3. Dependents not meeting the definition of a dependent, i.e., a girlfriend, grandchildren, or a child who is not a full-time student.

Some procedures that are followed to prevent misrepresentation on applications include:

1. Confirmation phone calls to proposed insureds to confirm data on application forms.
2. Inquire of employer if he has knowledge of any medical conditions of his employees or their dependents.
3. Medical records requested in some cases and compared with information submitted on the application.
4. Wage and tax statements required to verify employees are actually on the payroll.

Special Investigations Unit procedures upon receipt of referral of suspected eligibility fraud:

- A. View claims history and notepads
- B. Determine need for investigation
 1. No investigation needed
 - a. Document
 - b. Process claims
 2. Investigation needed
 - a. Request all pertinent documents
 1. Enrollment card
 2. Group file
 3. Claims
 4. Certificate

- b. Flag insured in system
- c. Send appropriate letters and make phone calls
- d. Make determination from information received
 - 1. If eligible for coverage, process claims
 - 2. If ineligible, make decision on course of action
 - a. back term
 - b. term current
 - c. rescind coverage
- 3. Send appropriate letters
- 4. Record savings
- 5. Report case to appropriate law enforcement authorities and the Maryland Insurance Commissioner

PREVENTION OF CLAIMS FRAUD

Benefit analysts are trained in fraud prevention by being made aware of typical fraud techniques such as:

- 1. Alterations of bills
 - a. Dates of service on Sundays or holidays
 - b. Charges that don't coincide with diagnosis
 - c. Whiteouts
 - d. Different color inks used
 - e. Erasures or strikeovers
 - f. Photocopied bills
 - g. Total incorrect
- 2. Fabrications of bills
 - a. Similar handwriting or typing on bills and employee-submitted claim envelopes
 - b. Dates out of sequence
 - c. Identical invoice #/different dates
 - d. Mixture of handwritten and typed charges on one claim
 - e. Misspelled medical terminology
 - f. Insured requesting direct payment for large bills with indication of no other insurance
 - g. Provider not in insured's geographic region
 - h. Employee in other state than company (watch for affiliates)
 - i. Repeated occurrence of accidents
 - j. Large bills incurred just prior to term date or immediately after effective date
- 3. Other "red flags" on bills
 - a. Age of patient: student or retiree too old to be on policy, treatment not logical for age of patient
 - b. Notes regarding retiree/unemployed status
 - c. Discrepancies with medical records, i.e., pre-x, disability, divorced

Definition of Provider Fraud:

The devising of any scheme by any provider of health care or services to defraud for the purpose of personal or financial gain by means of false or fraudulent pretenses, representations or promises.

Examples of Provider Fraud:

1. Billing for services not rendered.
2. Billing a non-covered service with a false diagnosis to obtain coverage.
3. Providing "free" services.
4. Non-qualified practitioners billing as qualified practitioners.

Special Investigations Unit procedures upon receipt of referral of suspected provider fraud:

- A. View claims history and all notepads
- B. Determine need for investigation
 1. No investigation needed
 - a. Document in tracking system
 - b. Process claims
 2. Investigation needed
 - a. Send appropriate letters and make phone calls
 - b. Make determination
 1. Process/deny claims
 2. Refer to outside investigative agency
 3. Refer to claims for recovery of overpayments
 4. Refer to collections
 - c. Record savings
 - d. Document in tracking system
 - e. Report case to appropriate law enforcement authorities
 - C. Determine if provider should be flagged in the system for future claims
 1. Request provider activity report
 2. Request and review in-house claims
 3. Update system if provider is to be flagged

Definition of Insured Fraud:

The commission of acts of deception, misrepresentation or concealment by any policyholder or group of policyholders in order to obtain something of value to which they would not otherwise be entitled.

Examples of insured fraud:

1. Alteration of bills
2. Submission of false claims
3. Failure to disclose information on applications, accident inquiries, C.O.B. and full-time student information requests, etc.

Special Investigations Unit procedures upon receipt of referral of suspected insured fraud:

- A. View claims history and all notepads
- B. Determine need for investigation
 1. No investigation needed
 - a. Document tracking system
 - b. Process claims
 2. Investigation needed
 - a. Request all pertinent information
 1. Enrollment forms
 2. Group file
 3. Claims insured activity report
 - b. Flag insured in system to route claims
 - c. Make appropriate phone calls/letters
 - d. Make determination
 1. Process/deny claims
 2. Refer to outside investigation agency
 3. Refer to claims for recovery of overpayments
 4. Refer to collections
 - e. Record savings
 - f. Document in tracking system
 - g. Report to appropriate law enforcement authorities

REPORTING OF FRAUD-RELATED DATA
TO THE INSURANCE COMMISSIONER

Procedures currently in place for routine reporting of fraud-related data to states with such requirements will be followed in the same manner for Maryland.

Special requests for data will be forwarded to the Special Investigations Unit and given priority handling upon receipt of a specific, written request for information. Data will be compiled and submitted to the Insurance Department or Commissioner as requested.

REFERRALS OF FRAUD CASES TO
LAW ENFORCEMENT AUTHORITIES

Employers Health Insurance is committed to aggressive investigation and referral for prosecution of health care insurance fraud by insureds, providers, agents, company employees and other individuals. The Special Investigations Unit is charged with the coordination of referrals to law enforcement authorities, working with the appropriate departments within the company to provide the maximum possible assistance to law enforcement officials, in compliance with state and federal laws. Referrals may be made to state fraud bureaus, the U.S. Postal Inspectors, Federal Bureau of Investigation (F.B.I.), U.S. Dept of Health and Human Services (DHSS), state medical licensing and disciplinary boards, state insurance commissioners, National Health Care Anti-Fraud Association (NHCAA), Insurance Crime Prevention Institute (ICPI), federal, state and county attorneys, local police departments, Immigration and Naturalization Service (INS), Internal Revenue Service (IRS), or any other appropriate authority.

CONTRACT MANAGEMENT OVERVIEW

"A Penny Saved Is A Penny Earned"

Employers Health is a strong and vital industry leader. We are good at delivering top-notch health insurance products in the most cost-effective manner possible. Employers Health is good at managed care.

How do we do it? Smart money management! To eliminate waste and control cost, Employers Health has an aggressive claims cost management system. It saves millions of dollars yearly, and we pass the savings on to our insureds in the form of lower premiums.

MISSION STATEMENT

Our mission is to provide quality service to our customers both internal and external while managing claims costs by maximizing the savings to which we are entitled to under the rights and provisions of our contract.

The Claims Cost Management Division is comprised of two departments, Medical Management Department and Contract Management Department. This overview will concentrate on the Contract Management Department.

The primary responsibility of the Contract Management Department is to control claim losses through fraud control and subrogation.

Health care expenditures are growing at a rate three times the rate of inflation. Health care fraud contributes significantly to this escalating cost of health care and insurance. Employers Health is seriously committed to combating fraud. We take every opportunity to exercise all the rights that are available to us under the terms and conditions of our policy and all the remedies we are entitled under the law. Employers Health is a founding member of the National Health Care Anti-Fraud Association (NHCAA), which is an association of private insurers, Blue Cross and Blue Shield organizations, self-insured corporations, and federal and state regulatory and law enforcement agencies. NHCAA's mission is to enhance the identification, prevention, detection and prosecution of health care fraud. To that end, NHCAA promotes information-sharing among members, engages in public education on health care fraud issues, trains members and non-members alike through national and regional conferences, seminars and workshops and serves in an advisory capacity to industry, regulatory and legislative bodies.

Employers Health has formed a Special Investigation Unit which is responsible for the detection, investigation, and prevention of all potentially fraudulent claims. It works very closely with both regulatory and law enforcement agencies in the documentation and prosecution of fraudulent claims. Our Special Investigation Unit integrates fraud training with training programs of other operational areas to enhance their staff's ability to recognize specific fraud indicators. This generates referrals to the Special Investigation Unit of potentially fraudulent claims for investigation. Our Special Investigation Unit will also initiate whatever action is necessary to recover payments made from the perpetrators-of fraud.

Employers Health is well recognized as a pioneer among health insurers in the area of subrogation. It was one of the first to include a subrogation clause in a health insurance policy and to form a Subrogation Department to aggressively exercise this legal right.

Substantial savings can and are achieved through subrogation. The primary objective of Employers Health's Subrogation Department is to control claims costs by recovering benefits paid against responsible parties and by having other insurers accept the primary responsibility of paying the claim. Subrogation action can arise due to automobile accidents, home or premises accidents, defective or hazardous products, medical malpractice, pollution or release of toxic substances, to mention just a few examples. Our subrogation personnel investigates claims that are identified to have subrogation potential, ascertain facts and information that are needed to determine and evaluate legal liability. They also investigate claims that are or may be payable under workers compensation or similar laws or by other non-health insurers. For example, claims for injuries sustained in an automobile accident are primarily payable under the medical payments coverage of the automobile insurance which generally pay for expenses from the first dollar up to a certain coverage limit. This will reduce or eliminate out-of-pocket expense such as deductibles and co-insurance which the insured would have otherwise incurred if the claim was made through their health insurance. Additionally, this will preserve the health plan's lifetime maximum benefits thus making more health benefit dollars available for any future catastrophic health claims that the insured may face.

Whenever another party can be held legally liable for causing an illness or injury, Employers Health Insurance can initiate whatever action is necessary to recover the benefits paid on behalf of the insured. In Self-Funded Plans, if Employers Health Insurance succeeds in recovering from the responsible party, and it usually does, Employers Health Insurance will return the funds recovered to the Plan.

These recoveries from responsible parties and savings generated from having other insurance coverages pay for the benefits will ultimately reduce the overall cost of providing your Plan benefits. It certainly will make more funds available to provide more benefits, improves business profitability and enhance opportunities for investments or other endeavors for the growth and security of the business and its employees.

By managing health care and health costs, Employers Health can make sure you get the most for your benefit dollar. Bringing you and your family high quality care and controlled costs is our goal at Employers Health.

COST MANAGEMENT PLAN
for
EMPLOYERS HEALTH INSURANCE COMPANY
and
LINCOLN NATIONAL LIFE INSURANCE COMPANY

Topic/Area One: Integrated Systems for Health Care Delivery

Employers Health Insurance Company, nor our affiliate, Lincoln National Life Insurance Company, operates a Preferred Provider Organization (PPO) within the State of Montana, and therefore does not market PPO health benefit plans to Montana employers. Our business plans do not call for the development of such plans within this state. We presently market and issue our traditional indemnity health plans with various cost containment features to Montana employers.

Employers Health Insurance does own and operate various PPO networks throughout the United States. PPO plans account for over half of our business. We are in the process of developing various Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs) and other gatekeeper-style arrangements.

(Item #3) Our cost containment plans include the following features, which if certain criteria are met and complied with, offer additional benefits at a reduced rate:

1. Second surgical opinions payable at 100%;
2. Home health care in lieu of hospital confinement payable at 100%;
3. Hospice care for the terminally ill in lieu of hospital confinement payable at 100%;
4. Audit of medical bills (if error is discovered, we will pay 50% of our savings); and
5. Birthing center benefits payable at 100%.

Furthermore, our cost containment plans require pre-admission certification of hospital admissions and non-emergency outpatient surgeries.

Topic One

page 2

These plans standardly include benefits for 30 days of skilled nursing facility care per calendar year provided certain criteria are met. Limited home health care visits are also standardly provided.

The employer is allowed flexibility in choosing the following cost-effective services to meet it's employees needs:

1. Prescription drug card services - reduced copayment charged if generic drug dispensed;
2. Routine care benefits payable at 100% up to \$100 per insured, per calendar year;
3. Accident benefits payable at 100% up to \$300 if services rendered within 90 days of accident.

COST MANAGEMENT PLAN
for
EMPLOYERS HEALTH INSURANCE COMPANY
and
LINCOLN NATIONAL LIFE INSURANCE COMPANY

Topic/Area Two: Quality Improvement and Assessment

(Item #9) Please refer to the attached document entitled "Quality of Services."

QUALITY OF SERVICES

Employers Health has the capability, through its recently acquired MEDSTAT database reporting system, to assess the quality of health care services provided to its enrollees as defined by any number of criteria including readmission rates, length of stay, mortality and complication rates, and similar categories. The use of MEDSTAT allows us to compare our experience against MarketScan norms, the MEDSTAT database fed by every entity that utilizes its product. At present, we have an inpatient measurement tool in place. Later this year we anticipate the capability to report on outpatient data that will measure services and cost results per specified treatment categories, to measure physician efficiency and quality and detect aberrant patterns of practice.

Our data can be sorted by a wide array of criteria, virtually any field contained within the data base. Entire networks can be compared to MarketScan norms, or individual hospitals compared to network norms or to one another. Results are shown in what is called a Quality of Care Indicators Report which summarizes data by various categories. Within any category, additional detail is available through an Audit report. Attached are representative samples of these reports in their standard formats. Employers Health can work with the State to customize reports should that be desired.

The Quality of Care Indicators report examines several aspects of inpatient care, including:

Readmissions within a certain time period,

Length of stay outliers,

Complications resulting from the patient's treatment during hospitalization,

Admissions for selected "tracer" conditions and discretionary surgeries,

Deaths.

Employers Health's experience in each of these categories is compared to the median and to the 75th percentile of MEDSTAT client experience. If the experience is above the 75th percentile for any indicator (i.e., more than 75% of MEDSTAT clients had a lower percentage of cases flagged), this questionable pattern is highlighted in the report.

The quality of care screening categories used as the basis for analysis are explained below.

OUTLIERS

Cases are flagged as *short-stay outliers* when the length of stay is less than two standard deviations below the mean length of stay for that case's DRG. Cases with a length of stay greater than two standard deviations above the mean are flagged as *long-stay outliers*. A high proportion of outlier cases can indicate problems

related to the process of care. Short-stay outliers may represent patients discharged before completing an appropriate course of treatment. Long-stay outliers may result from inappropriate management of the patient during hospitalization, additional complications, or unexpected outcomes due to less than optimal care.

READMISSIONS

All readmits are cases for which the number of days between admissions, measured from the day of discharge to subsequent admission, is less than the number of days specified as a readmission screen when generating the report. High rates of readmission can indicate ineffective treatment during prior admissions or a lack of continuity of care, such as inadequate follow-up.

Readmits after short stay represent patients readmitted following discharge for a case flagged as a short-stay outlier. The percentage indicates what proportion of short-stay discharges resulted in a readmission within the time period specified in the readmission screen. This indicator screens for a pattern of readmissions that may have resulted from discharges prior to the completeness of appropriate treatment.

Short-stay readmits are readmissions for an exceptionally short period following any discharge within the selected readmission time window. These readmissions may indicate poorly managed follow-up care after the prior stay or an inappropriate setting for follow-up care.

Long-stay readmits are readmissions for an exceptionally long period. They may represent patients who developed complications as a result of their prior admission or because of inadequate follow-up care. However, they may also be attributable to an older mix of patients or patients with severe conditions requiring frequent admission. Case audits help to differentiate these cases from those with quality of care problems.

COMPLICATIONS OF TREATMENT

Complications of treatment include patients who developed complications as a result of treatment during the course of their hospitalization. Included in this screening category are post-operative infections, complications from surgery or other therapy, and adverse reactions to medications or transfusions. Although some of these complications occur even with optimal care, a pattern that is inconsistent with MEDSTAT client experience may suggest inappropriate care.

Complications of treatment by DRG (diagnostic related group) include:

- 418 Post-Operative and Post-Traumatic infections
- 452 Complications of Treatment
- 453 Complications of Treatment

TRACER CONDITIONS

Tracer conditions include diagnostic and treatment categories where a high degree of medical discretion is involved in the decision to admit a patient or perform a procedure. When a high percentage of cases are flagged for these conditions, concern exists not only about potentially unnecessary care, but about the added risk to the patient.

Tracer conditions are analyzed within three categories:

Discretionary surgeries: As a percentage of all surgeries.

Questionable medical: As a percentage of all medical admissions.

Caesarean sections: As a percentage of all deliveries.

Tracer conditions are based on groups of DRGs; in order to be screened for these conditions, cases must have a valid DRG assigned.

Discretionary surgeries by DRG include:

79 Respiratory Infections & Inflammations Age > 17
80 Respiratory Infections & Inflammations Age > 17
81 Respiratory Infections & Inflammations Age 0 - 17
89 Simple Pneumonia & Pleurisy Age > 17
90 Simple Pneumonia & Pleurisy Age > 17
91 Simple Pneumonia & Pleurisy Age 0 - 17
101 Other Respiratory Infections
102 Other Respiratory Infections
320 Kidney & Urinary Tract Infections Age > 17
321 Kidney & Urinary Tract Infections Age > 17
322 Kidney & Urinary Tract Infections Age 0 - 17

Questionable medical admissions, by DRG, include:

59 Tonsillectomy & Adenoidectomy Age > 17
60 Tonsillectomy & Adenoidectomy Age 0 - 17
164 Appendectomy with Complicated Principal Diagnosis
165 Appendectomy with Complicated Principal Diagnosis
195 Total Cholecystectomy with Bile Duct Exploration
196 Total Cholecystectomy with Bile Duct Exploration
197 Total Cholecystectomy without Bile Duct Exploration
198 Total Cholecystectomy without Bile Duct Exploration
209 Major Joint and Limb Reattachment Procedures
210 Hip & Femur Procedures excluding Major Joint Age > 17
211 Hip & Femur Procedures excluding Major Joint Age > 17
212 Hip & Femur Procedures excluding Major Joint Age 0 - 17
218 Lower Extremity & Humerus Procedure except Hip, Foot, Femur Age > 17
219 Lower Extremity & Humerus Procedure except Hip, Foot, Femur Age > 17
220 Lower Extremity & Humerus Procedure except Hip, Foot, Femur Age 0 - 17
221 Knee Procedures
222 Knee Procedures
223 Major Shoulder, Elbow Procedure or Other Upper Extremity Procedure
224 Shoulder, Elbow, Forearm Procedure excluding Major Joint
225 Foot Procedures

DEATHS

Deaths are cause for concern if they are the result of inappropriate care. The Percent column in this screening category indicates the percentage of all cases in which the patient died during the course of hospitalization as a percentage of all cases where a discharge status was recorded. The normative comparisons are not adjusted for patient age, condition, severity, or expected outcome. However, due to their relatively infrequent occurrence, deaths warrant review if your experience differs from normative mortality rates.

QUALITY OF CARE AUDIT REPORT

The Quality of Care Audit report lists cases which have been flagged for any quality of care indicator that you select. One can generate a list of all flagged cases or select a percentage sample of them.

For each flagged case, the Audit report displays:

The identification of the employee covered by insurance,

The identification of the patient (e.g., age, sex, relationship to the employee),

The identification of the provider,

Clinical information about the case, such as MDC, DRG codes and length of hospital stay.

COST MANAGEMENT PLAN
for
EMPLOYERS HEALTH INSURANCE COMPANY
and
LINCOLN NATIONAL LIFE INSURANCE COMPANY

Topic/Area Three: Utilization Management

Employers Health Insurance Company provides medical utilization management services for all of our health benefit plans and those in which we administer on behalf of Lincoln National Life Insurance Company. Such services are provided by Care Plus, our utilization review organization, which is accredited by the Utilization Review Accreditation Commission, Inc. (URAC). We have recently filed for accreditation by the National Commission for Quality Assurance (NCQA). The objective of Care Plus is to contain or reduce costs by providing health care without sacrificing the quality of care provided to the insured patient. The four main services performed by our utilization review organization are:

1. Pre-certification;
2. Concurrent Review;
3. Discharge Planning; and
4. Case Management.

(Items #12 - 16) Please refer to the attached manual which outlines our complete utilization management/review program.

(Item #17) We have an area within our company that specializes in the pre-payment review of claims. This area reviews and approves claims of more than \$12,000 and decide whether a hospital bill audit/review is needed. This goal of this review is to catch overcharges or items usually not required for the diagnosis presented.

COST MANAGEMENT PLAN
for
EMPLOYERS HEALTH INSURANCE COMPANY
and
LINCOLN NATIONAL LIFE INSURANCE COMPANY

Topic/Area Four: Alternative Mechanisms for Payment to Providers

(Item #22) We have an area within our company that works with non-PPO providers, usually hospitals, to develop discounts. These negotiators will offer to have the claim paid within 7-10 days if the provider agrees to apply a discount (usually between 3-5%). In 1993, these area saved \$2 million for our customers.

* Please note that we do not have any contracts with any health care providers or facilities within the State of Montana.

Our cost containment plans offer the following deductible/coinsurance options:

- \$100 or \$250 calendar year deductibles (maximum of 3 per family);
- \$500 or \$1,000 calendar year deductibles (maximum of 2 per family);
- \$2500 or \$5000 coinsurance limits.

If the optional Prescription Drug Card (PCS) benefit is elected, there is a \$5 copayment for generic drugs and a \$10 copayment for brand name drugs.

Lincoln National Life Insurance Company's group health plans (aka - LGT plans) contain a mail order pharmacy benefit which pays 100% of the cost for covered prescription generic maintenance drugs. For covered brand name drugs, a \$5.00 copayment applies.

COST MANAGEMENT PLAN
for
EMPLOYERS HEALTH INSURANCE COMPANY
and
LINCOLN NATIONAL LIFE INSURANCE COMPANY

Topic/Area Five: Third Party Liability/Coordination of Benefits

(Item #32) Please refer to the attached document entitled "Contract Management Overview" which explains our subrogation process. We have also attached our Claims injury investigation guidelines/standard procedures. (* NOTE: Procedures may vary according to the various state mandates.) These guidelines outline the initial step to our complete subrogation (recovery) process. We strongly believe that having this process in place promotes accuracy in claims payment, uniformity and a substantial costs savings to our customers.

(Item #31) All of our health contracts standardly contain a coordination of benefits provision, however they may be variance in the language and procedure followed according to state mandates. Our Claims department has guidelines in place which are strictly adhered to promote cost savings.

We have found it is cost-effective to update our COB information for insured dependents on a six month basis. A phone call is made to the insured or a letter is sent requesting such information. If it is determined that other insurance is present, our Claims department follows guidelines to ensure claims are processed in a timely fashion and the insured is always informed of the claims status. Attached are our standard Claims procedures/guidelines for obtaining other insurance payment information.

RECEIVED

MAY 10 1994

Fortis Benefits
Insurance Company
P.O. Box 64271
St. Paul, MN 55164-0271
(612) 738-4000

MONTANA HEALTH CARE AUTHORITY

May 5, 1994

Montana Health Care Authority
P.O. Box 200901
Helena, MT 69620-0901

Re: Cost Management Plan

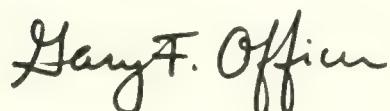
Gentlemen/Ladies:

Enclosed is our Cost Management Plan as requested in a January 7 Memo from Dorothy Bradley.

We apologize for the delay in responding, but this floated around in our company before it got to the appropriate department. At that time, we talked with Mike Craig of your office, who gave us an extension.

If you have any questions or need any additional information, please contact me at the telephone number specified below.

Sincerely,



Gary F. Officer
Compliance Analyst
Law Department
1-800-800-2000, extension 4280

fortis

COST

MANAGEMENT

PLAN

Fortis Benefits Insurance Company

March 1994

COST MANAGEMENT PLAN FORTIS BENEFITS INSURANCE COMPANY

Integrated Systems for Health Care Delivery

Fortis' current status is one of general insurer providing medical coverage with an integrated utilization review component provided by Private HealthCare Systems, Inc. This program includes pre-admission certification and continued stay review. We further provide case management services for catastrophic cases through an in-house team of nurses who coordinate resources and substitute benefits, as appropriate, in order to provide long-term catastrophic care in the most cost effective manner. Fortis has introduced a managed care pharmacy network on a national basis which features generic substitution drug utilization review and deeper discounts through selected contracting on a nationwide basis. Fortis routinely communicates with Pronet, a network of hospital discount arrangements to take advantage of reimbursement arrangements with hospital providers in our non-PPO markets.

Fortis' current direction is to develop a strong managed care program on a nationwide basis. We currently operate PPOs in over 60 markets, as well as risk bearing point-of-service plans or exclusive provider organizations in San Francisco, Los Angeles, San Diego, Sacramento, Chicago, Phoenix, Dallas, Central California, Boston, and Atlanta. The EPO model, when combined with steep benefit differentials and positive primary care enrollment, has resulted in an increase in service level being rendered by the primary care providers directly or on referral compared to our PPO experience and significantly reduced costs from either our PPO or indemnity experience in these markets. The EPO type plan design further credentials providers to sit not only on licensure and service availability, but also on experience with utilization management as an internal function, rather than an additional burden imposed by the insurance company.

Through Private HealthCare Systems, Fortis has implemented a national access measurement tool utilizing the geo-access computer mapping software. Through application of this software we were able to constantly analyze the distribution of primary care physicians relative to the 1990 census distribution. By establishing a standard of two primary care physicians within eight miles of each insured, Fortis is able to produce detail analyses of which communities within a given market meet the standard. This information is used to direct contracting effort at underserved areas and make the most effective and efficient use of administrative resources for the carrier and the network.

Quality Improvement and Assessment

Fortis currently relies on contracted networks for quality assessment and quality improvement programs. Networks primarily use patient feedback surveys to measure outcomes of care, utilize patient perception of process and treatment as proxies for more statistically significant outcomes measurement. Fortis currently collects information on statistical treatment pattern and physician treatment pattern. This information is routinely

provided for actuarial analysis, claims review and cost control. Interaction with providers in the majority of settings is primarily a function of Fortis' contracts with their respective networks. However, direct action and feedback relative to deviations from community standards of office practice administrative procedures and patient outcome is often communicated directly by Fortis' staff with providers.

Utilization Management

Fortis routinely applies in-patient readmission certification, out-patient surgical review, length of stay-review and location of care analyses on all admissions and outpatient surgeries. Comparisons are drawn from local, regional and national norms. Intervention and physician practice is inversely proportional to compliance in that providers who submit all information according to utilization guidelines or known expectations receive very few calls from UR staff while physicians who do not attempt to comply are targeted for more intensive intervention. Fortis' internal large case management department provides a complete array of coordination services to assure the most cost-effective delivery of covered benefits and catastrophic situations.

Through Private HealthCare Systems, Fortis participates actively in supporting the physician quality monitoring program nationwide in which all participating physicians are credentialed to PHCS standards initially. Then on an annual basis a profile including all claims activity, all pre-cert activity and compliance, any administrative referrals or patient complaints and any specific references in patient satisfaction surveys are reviewed in a recredentialing process. Results of the PQM Program may be termination of provider contract or, depending on severity, frequency, etc. this program can lead to monitoring measurement, evaluation or reward (referrals of new patient requesting redirection to a physician).

Fortis provides in-house close payment claims review through a combination of automated code review and code usage software, aggressive subrogation, COB fraud and supplemental negotiating staff.

Fortis' drug program is fully detailed in the first section of this analysis and is applied to all lines of business.

On an annual basis, Fortis aggregates utilization statistics for each market and each network under contract and evaluates continued participation in these markets and networks through use of comparative data of competing networks and regional and national norms.

Alternative Mechanisms for Payment

In Fortis' non-managed care markets, Fortis reimburses according to the 80th, 85th and 90th percentiles of community HIAA data, depending on type of service incurred. Non-PPO hospitals are reimbursed according to the bill of charges submitted for the service. However, claims review, fraud, COB and subrogation review, in addition to proactive non-managed care negotiation services are used to attempt to control costs. In managed care environments, Fortis is a strong advocate of prospectively set reimbursement, hospital per

diems and per case or DRG based payments as well as standard coding based fee schedules for physician and non-physician providers where possible. Through Private HealthCare Systems, Fortis has access to a nationwide network of transplant centers or centers of excellence for tertiary care and, many of Fortis' hospitals are currently being approached to negotiate ambulatory case reimbursement for out-patient surgery on a prospectively set case basis. In Fortis' EPO model, primary care providers agree to a lower than normal fee schedule in exchange for bonus opportunity of up to 20% of services rendered should total medical costs incurred by the population be held below managed care standards on a per number per month basis. This bonus arrangement in California has resulted in utilization similar to open-access HMO models and a dramatic reduction in medical premiums.

Third-Party Liability and Coordination of Benefits

As indicated in the previous section, Fortis routinely applies aggressive third party liability and coordination of benefits program utilizing primarily internal resources and staff in conjunction with specific vendors and external investigative programs.

Administrative Methods

Fortis currently accepts all standardized claim formats and is currently moving toward the implementation of a state-of-the-art claims system able to receive any standardized claim forms electronically and automatically enter the claims into the adjudication system applying all data capture programs and standardized claim review software. Fortis currently produces standardized remittance advice and explanation of benefits formats and is able to maintain claim turnaround time at or below national standards for similar companies. Fortis' managed care program has moved to electronic or machine readable data entry and provider updates in order to be able to facilitate accurate contract handling, directory production and claims adjudication.

Anti-fraud

Some aspects of our fraud controls were previously discussed. Other aspects are contained in the attached Policy Statement on Fraud and Abuse.

General American

GROUP CLAIMS SUPPORT
Rudy A. Schmitz, Director

March 25, 1994

NATIONAL SERVICE CENTER
Post Office Box 14490
St. Louis, MO 63178
(314) 843-8700

Ms. Dorothy Bradley
Montana Health Care Authority
28 N. Last Chance Gulch
P.O. Box 200901
Helena, Montana 59620-0901

RE: Cost Management Plans

Dear Ms. Bradley

Attached is correspondence which recaps General American's Cost Management Plans.

Please note that Mr. Mike Craig of the Montana Health Care Authority extended our deadline to March 25, 1994.

Questions regarding these Plans should be directed to Ms. Judi Taylor, Managed Care Consultant, at (314) 525-3675.

Sincerely,



Sandra K. Swyers
Insurance Specialist

/sk

Attachments

cc: Linda Maus - Group Contracts
Paula Novak - Group Financial Services
Judi Taylor - Managed Care



**General American Life Insurance Company
Cost Management Plans
March, 1994**

NATIONAL SERVICE CENTER
Post Office Box 14490
St. Louis, MO 63178
(314) 843-8700

TOPIC/AREA ONE: Integrated Systems for Health Care Delivery

General American Life Insurance Company offers both standard and flexible benefit packages. Many of the standard plans offer preventive services such as immunizations, mammography and, physical examinations. A wide range of plans and funding mechanisms are available to General American Life Insurance Company prospects and clients.

One example of health education promotion is the offering of a prenatal program which monitors the pregnant mother by professionals throughout pregnancy. This program also provides her with education materials about her pregnancy. These materials are approved by the American College of Obstetrics and Gynecology. General American Life Insurance Company also has available an evaluation tool for employees to determine their wellness status based on lifestyles.

A variety of posters, payroll stuffers and a quarterly published newsletter on health maintenance are also available to General American clients.

The use of home-based care is encouraged through the benefit plans in that each contains a home health care benefit. To further encourage home-based care, offered is a case management program. This program promotes the use of outpatient settings of all kinds, including intensive outpatient treatment modalities, for mental health/substance abuse treatment. This program provides management to achieve coverage for the most appropriate level of care. An additional offering is a benefit for skilled nursing facility care.

General American utilizes Private Healthcare Systems, Inc. for a national network of providers for both Preferred Provider Organization and Point of Service products however at this time Private Healthcare Systems has not expanded its network development to the State of Montana. Private Healthcare Systems is a managed care company with corporate offices in Waltham, MA. General American Life Insurance Company is a Class A Shareholder in Private Healthcare Systems, Inc. General American also is financially involved with GenCare/Sanus, a St. Louis, MO regional Health Maintenance Organization, Preferred Provider Organization and Point of Service product provider. Additional agreements exist with providers and managed care entities to meet the needs of our clients.

An innovative product unique to the insurance industry is the option to use the Prospective Nursing Care Review program. Home health nursing care is precertified and continued care is certified. This unique benefit promotes cost-effective medically necessary home health care for each covered individual and prevents situations of non-payment after medically unnecessary home nursing care has been rendered.

With respect to quality, General American houses a quality assurance department of 30 plus staff. General American also has a full time medical director position with a full panel of specialist consultants.

Other cost containment and benefit control features at General American include:

- Code Review
- Fraud Detection and Control
- Hospital Bill Audit
- Special Rush Service Discounts
- Large Claim Negotiations
- Assistant Surgeon Fee Review

TOPIC/AREA TWO: Quality Improvement and Assessment

Through requests for proposal the quality assessment of contracted providers occurs for all General American insureds. Patient satisfaction surveys are used to assess ongoing quality. Standard credentailing pertinent to the provider entity is required. Standard quality of care investigation procedures exist to research concerns expressed by covered individuals. Providers under scrutiny are flagged on the computer system.

Private Healthcare Systems, Inc. has a Total Quality Management System which is described in detail in the attached booklet. This state-of-the-art program is used by the utilization review program at Private Healthcare Systems, Inc. which is an option of General American Life Insurance Company clients.

TOPIC/AREA THREE: Utilization Management

General American Life Insurance Company clients are offered and encouraged to take advantage of utilization review which is standardly provided by Private Healthcare Systems, Inc. This program serves over five million covered individuals and provides a full range of utilization review services:

- Pre Admission and admission review
- Concurrent Review
- Discharge Planning
- Outpatient Review (Surgery, Selected Procedures)

A standard appeals process exists with this feature.

The Total Quality Management Program (see attached booklet) is used by the Private Healthcare Systems, Inc. utilization review program.

Case Management is performed in St. Louis, Mo by General American Life Insurance Company associates with a computer link to the Private Healthcare Systems utilization review program. This is a nationwide program that uses five case management companies to perform on-site assessments where indicated. Registered nurse specialists in all medical specialties assess, evaluate, plan the course of treatment, oversee implementation and monitor progress of the patient. The program is a voluntary option for the covered individual.

Pre-payment review of claims occurs with all home health nursing care claims, any claim where providers are flagged in the computer system, claims identified by Code Review, hospital bills exceeding specified parameters, all claims over \$100,000 and any claims identified by examiners as unusual.

Post payment review occurs when contractual obligations of providers to refund payments is requested or when a provider is newly identified with potentially fraudulent or excessive

billing. Focused and standard audits are performed on an ongoing basis to ensure accurate and timely claim pay.

On an ongoing basis audits of utilization review and case management are performed randomly and internally. Periodically a third party audit firm reviews these processes. Clients may audit both processes using external resources upon request.

General American Life Insurance Company utilizes the services of PCS for its drug card program in Montana. Cases not situated in Montana but with covered individuals living in Montana may utilize the mail services of Express Scripts. Information on both companies are enclosed in this material.

General American Life Insurance Company and Private Healthcare Systems, Inc. provide a wide range of reports for

- Collection, analysis, and interpretation of health care statistical data to determine effectiveness of cost management measures, to design benefits and to better manage care. (See attached Health Plan Management Reports as one example)
- Processes to measure ongoing effectiveness of utilization review and eliminate ineffective procedures (See Private Healthcare Systems utilization report as example)
- In the aggregate: for example cost effective substitution of services, advantages of alternative benefit programs, overall insurer savings (see Catastrophic Case Management Reports as example)
- Reports are generated at standard intervals to clients (monthly, quarterly, at case closure) with periodic client meetings to recommend benefit changes based on results.

TOPIC/AREA FOUR: Alternative Mechanisms for Payment to Providers

A Centers of Excellence is available to covered individuals via the case management program for transplant procedures.

A balance of the most appropriate copayments and deductibles is evaluated with the client for desired outcome for both hospitals and professionals as well as outpatient hospital services.

Code Review is a standard part of the claim adjudication process as is hospital bill audit. HIAA data is used for calculating reimbursement.

A deductible is typically applied where hospital admission is not required.

National agreements for specific nursing services exist within the case management program.

TOPIC/AREA FIVE: Third Party Liability Coordination of Benefits Strategies

There is an evaluation of claims for potential third party liability through the process of system edits by diagnostic (ICD-9) codes.

The attached Health Plan Management reports demonstrate General American's ability to provide reports on Third Party Liability/Coordination of benefits activities.

With coordination of benefits, General American provides cost-effective updates of COB information files, timely response to customer inquiry and cost benefit analysis.

TOPIC/AREA SIX: Administrative Methods

General American accepts HCFA 1500, UB82 or UB92, the ADA-American Dental Association form, or other carrier's claim forms as well as the General American claim form.

Extensive claims data is captured on General American's system including:

- ICD-9-CM diagnosis codes
- CPT4 procedure codes
- UB-82 revenue codes
- Additional UB-82 data elements
- Place of service
- Types of service
- Utilization review approvals and denials

General American receives and uses UB-82 claim forms for hospital claims. We do also encourage paperless claims submissions either through NEIC or directly to General American using a compatible format.

General American performance goals require a specific percentage of all claims to be processed within 14 calendar days.

General American's standard is to pay claims within 14 calendar days after receipt if no additional information is needed. In some cases where further investigation is required, pursue the investigation and pay or deny the claim within 30 days after receipt of the claim submission.

NOTE: Some states have laws requiring fewer days. The claim payor is responsible for the following:

- * Conduct all phases of the investigation simultaneously. For example, if no information on spouse's employment is available *and* there is a possibility of a pre-existing condition, request all required information at one time.
- * If the claim cannot be processed within 30 days after receipt, inform the insured (in writing) of the reason 15 days after receipt of the claim.
- * If the claim cannot be processed within 60 days after receipt (45 days from the date of the initial notification), send another letter to the insured indicating why additional time is needed.
- * If the claim is still not resolved 60 days after receipt, send a letter to the insured stating why additional time is needed, and every 45 days thereafter, until claim handling is completed.

General American has established its processing goals to include 99% accuracy of benefit payments, and 96% coding accuracy.

TOPIC/AREA SEVEN: Anti-Fraud

To detect and control fraudulent claims, General American has the following programs:

Fraud Detection and Control:

This is a two-part program consisting of preventive and recovery efforts.

The best defense against fraud is education. Our claims examiners are trained to recognize the signs of fraudulent claims/services. Enclosed is a pamphlet that is an example of our on-going training efforts.

Another notable feature is a fraud "hotline" individuals can call to report suspected fraud. The toll free "800" number is printed on each Explanation of Benefits.

Recovery begins with our claim examiners and our COMPUTRAK claims system, which can flag claims from certain providers and employees when fraud is suspected. Some claims are denied outright, while others are pended until a review and/or investigation is conducted by the fraud investigative staff in the Managed Care/Benefit Control unit.

Further, General American is a corporate member and on the Board of Governors of the National Health Care Anti-Fraud Association. This membership provides us with information on the latest development in fraud schemes, legislation, and training. We also have access to a national database which contains information on providers currently under investigation and those who have been convicted of fraud.

We are also members of the Midwest Investigators Training Association, the Health Care Task Force of Eastern Missouri sponsored by the U.S. Attorney, and the Metropolitan St. Louis Health Insurance Task Force sponsored by local insurance companies.

We work with the FBI, Postal Inspector, local law enforcement officials, and private investigators as applicable.

Specialized Software:

General American uses an expert software system designed exclusively to reduce overpayment of physicians' claims. It applies accurate and consistent medical review criteria to each CPT-4 coded charge and documents the system's reasoning and results.

There are three common types of coding errors or misrepresentations made on physician's claims and that is detected by this software system:

- unlikely code combinations of procedures that do not make clinical sense
- "code creep" or upcoding, which occurs when physicians bill for more extensive (and expensive) procedures than they actually performed
- Unbundling, which occurs when physicians bill separately for the component parts of a procedure instead of, or in addition to, simply billing for the procedure itself

General American's fraud control program and specialized software help you manage your benefit dollars.



8505 East Orchard Road
Englewood, CO 80111 Tel. (303) 689-3000
Address mail to PO Box 1080, Denver, CO 80201

March 30, 1994

Montana Health Care Authority
P. O. Box 200901
Helena, Montana 59620-0901

Dear Health Care Authority:

Subject: Cost Management Plan

To comply with Senate Bill 285 we have prepared the attached "Cost Management Plan" as outlined in the request for "Health Insurer Cost Management Plans" dated November 10, 1993.

Please contact me if we can be of further assistance.

Sincerely,

A handwritten signature in cursive ink that appears to read "Nancy C. Campbell".

Nancy C. Campbell
Associate Manager,
Employee Benefits Managed Care

NCC:sf

Attachment: "Cost Management Plan"
COSTMGTP.LTR

INTEGRATED SYSTEMS FOR HEALTH CARE DELIVERY (Continued)

- "Well Newborn Care Covered Expenses" means:
 - routine nursery charges;
 - charges for Doctor's fees for an examination; and
 - charges for circumcision;for a well newborn infant through the first 7 days of its life.

A "high-risk maternity" program focuses on identifying, early in the pregnancy, females who are at high risk of having premature infants. Case Managers work with high-risk females to promote active physician care to prevent premature birth.

■ Health Promotion Objectives

- To maximize the effectiveness of our managed care programs.
- To reduce our customers health risks by enabling their employees to increase control over and improve their health in the areas of prevention, lifestyle, self-care, and effective utilization of services.

■ Health Promotion Strategy/Tactics

Rather than introduce a series of independent Health Promotion programs, our strategy is to expand the features of our managed care programs to include health promotion services that complement and further our over-all strategy to provide *fully integrated, seamless managed care services to our customers.*

Specifically, we will integrate Health Promotion activities with existing education tools, customer service functions and utilization management programs, as well as plan design, providing:

- Health Promotion services for all managed care plans to:
 - encourage members to adopt healthy lifestyles and reduce their health risks
 - educate members to be responsible healthcare consumers
 - assist members when they are sick, including minor, chronic and acute illnesses

INTEGRATED SYSTEMS FOR HEALTH CARE DELIVERY (Continued)

Following is a summary of the proposed strategy/tactics we implemented in 1993 and will implement in 1994.

Provide Health Promotion Services to all Managed Care Plans

In 1993:

- Added a Preventive Care Benefits feature to PPO Plans (versus current option).
- Developed Pre-Natal Care Education as a component of the Maternity Assessment Program, Great Beginnings.
- Redesigned and refocused employee communication tools to develop an effective consumer education program.
- Developed an "Ask-a-Nurse" service that is integrated with customer service and internalized utilization management programs.

In 1994:

- Enhance our Benefit Payment Customer Service capabilities to support Health Promotion.
- Introduce a Chronic Illness Management capability as a component of the "Ask-a-Nurse" Service.
- Introduced a Preferred Pharmacy Program designed to control the cost and quality of prescription drugs through the use of a network of pharmacies, which dispenses drugs, and utilization review conducted both at point of service and retrospectively.
- Employee Assistance Program (EAP), designed to encourage employees and their families to seek help in coping with personal problems before they interfere with work.
- Managed Mental Health, providing 24-hour access for assessment and referral of all mental health care.
- Managed Care Information Service (MCIS), service provided by Member Services. Assistance is available in choosing a doctor who meets their unique needs.

INTEGRATING HEALTH PROMOTION WITH MANAGED CARE SERVICES

Services Provided to All Managed Care Plans

Description of Health Promotion Capabilities	Services Provided to All Managed Care Plans						Utilization Management UR, CCM, QC, HRM, MHSA
	Preventive Care Benefits	Enrollment Meetings	Employee Communication Material	Pre-Natal Care Program	Enhanced BPO Customer Service HotLine	Ask-a-Nurse	
	General	MD Referral	General	General	General	Chronic Ill. Mgmt.	
Encourage Preventive Care	✓	✓	✓	✓	✓	✓	
Encourage Healthy Life-Styles		✓		✓		✓	
Facilitate High Risk Behavior Changes	✓			✓		✓	
Educate Members to be responsible Health Care Consumers	✓		✓		✓		
Help members find Network Providers to meet their needs			✓	✓	✓	✓	
Help members receive access to Quality Care				✓	✓	✓	
Educate Members on Self-Care for minor illnesses		✓	✓		✓		
Provide members with information on diagnoses and treatment					✓	✓	
Help members make informed health care decisions					✓	✓	
Facilitate Patient/Physician Communication				✓	✓	✓	
Identify members with chronic illnesses and help them manage their condition					✓	✓	
Identify high risk members and those with acute problems, helping them manage/improve their condition					✓		
Provide members with risk reduction/intervention programs negotiated with network providers						✓	

INTEGRATED SYSTEMS FOR HEALTH CARE DELIVERY (Continued)

- **Avoiding Institutionalization**

Outpatient care, such as Home Health Care, Pre-admission Testing, and Skilled Nursing Facility coverage are promoted in order to reduce utilization of acute-care facilities.

- **Provider Networks**

At present, there are no plans to establish a contracted provider network. We have options for competitive arrangements in the areas of Home Care services and supplies and prescription drugs.

TOPIC: QUALITY IMPROVEMENT AND ASSESSMENT

- **Contracting with Providers**

A Centers of Excellence network is available for patients requiring Heart, Bone Marrow, Kidney, and Liver transplants. Selection of facilities, such as Mayo Clinic and John Hopkins, was based on criteria such as experience of the transplant team and outcome (survival rates) results.

- **Provider Quality of Care Monitoring**

Although we do not have a provider network in Montana, I have attached a description of our "Provider Quality of Care Monitoring Program" which we use in areas where we do have networks.

TOPIC: UTILIZATION MANAGEMENT

The backbone of our Utilization Management program is Health Care Review Service. This program contains many components including pre-certification of admissions and surgeries and case management. Attached is a description of our Managed Care "Health Care Review Service".

Managed Care

Provider Quality Of Care Monitoring Program

Ongoing monitoring maintains quality and cost effectiveness.

In today's health care arena, there is growing concern over the quality and cost effectiveness of care delivered by managed care physicians and hospitals. While rigorous quality and cost screening is done during the provider selection process, it's also vital to track performance on an ongoing basis.

That's why a key component in the overall Medical Management System is the computer-based Quality of Care Monitoring Program. This program gives us a comprehensive way to monitor provider performance and refine our network based upon measurable results. Our underlying premise is that careful selection and ongoing monitoring yields high quality, cost-effective providers.

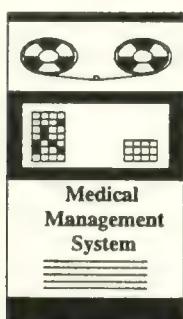
Providers Monitored To Ensure Continued High Standards

This emphasis on quality makes a difference to the value of your health care dollar. Through advanced computer analysis and evaluation by medical professionals, we make sure that providers continue to meet or exceed high standards in three key areas:

- Quality of care
- Patient service
- Efficiency of practice

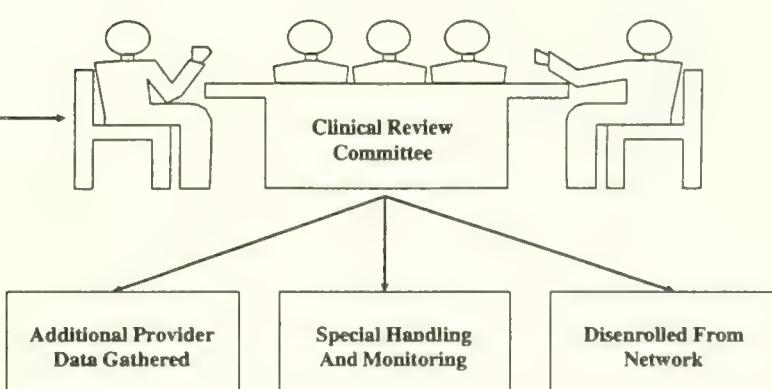
The Quality of Care Monitoring Program consists of a computerized monitoring system and an intervention process. We use this program because the only way to maintain quality and cost effectiveness is to set high standards and monitor performance on an ongoing basis.

Computerized Monitoring



Providers
Flagged
For Review

Intervention Process



Managed Care

Provider Quality Of Care Monitoring Program

Comprehensive Physician Monitoring System

The Quality of Care Monitoring Program uses current utilization management data and historical utilization patterns to monitor provider performance.

Historical utilization patterns are constructed of data from these sources:

- ***Claims Data*** — Physicians' claims are analyzed to detect frequent re-hospitalizations, the use of outmoded procedures and excessive testing.
- ***Utilization Management Data*** — The utilization management database is searched to find quality problems occurring during hospital admissions, the use of inappropriate health care settings, excessive length-of-stay extensions and other potential problems related to treatment plans. Each physician's history of compliance with our utilization management program is also examined.
- ***Prescription Drug Data*** — Prescription data is analyzed to detect inappropriate or excessive prescription practice patterns. Physicians who prescribe too many drugs simultaneously to their patients are identified.
- ***Patient Surveys*** — Random patient satisfaction surveys are conducted to determine physician accessibility, clarity of communication with patients, care provided during and after hospitalization and adequacy in the amount of treatment given.
- ***Physician Accessibility Surveys*** — Physicians' offices are called to check on off-hour coverage and appointment availability.
- ***External and Anecdotal Data*** — Potential quality problems are identified by consumers, regional network selection teams, and utilization management nurses and physicians.

The data from these sources are transferred into the provider administration database in the Medical Management System for computer analysis.

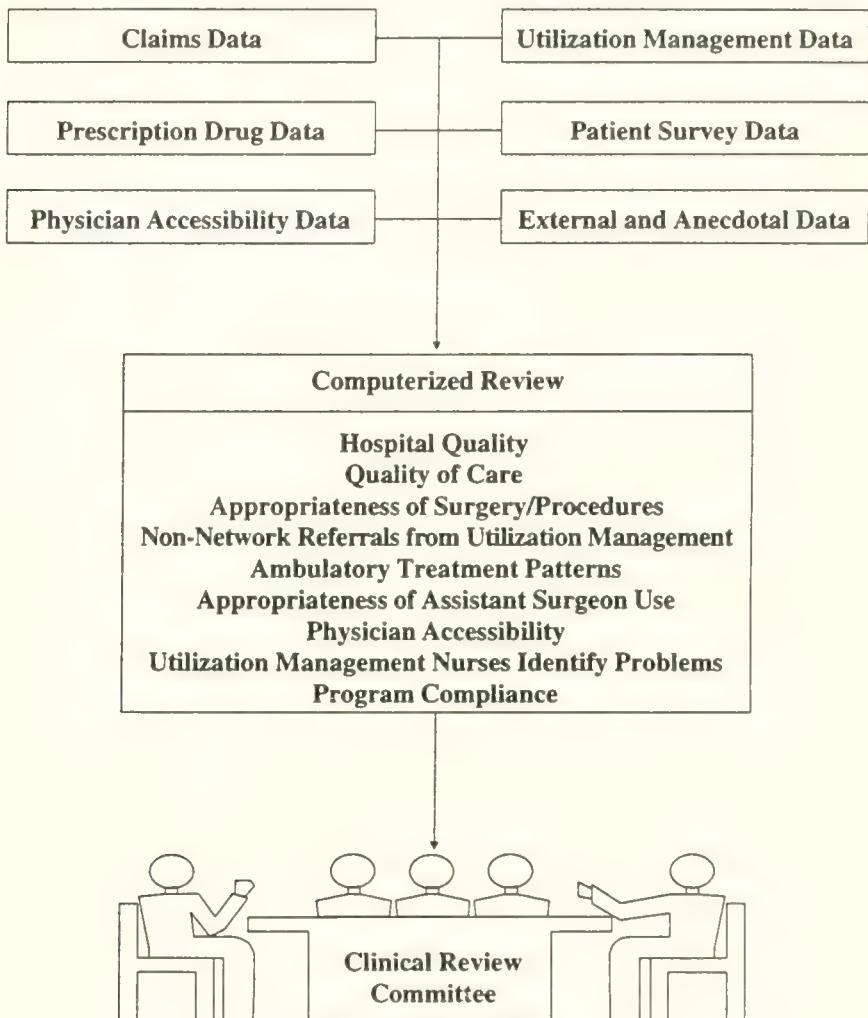
Managed Care

Provider Quality Of Care Monitoring Program

Computerized Screens Provide Comprehensive Profiles

In addition to collecting and analyzing data from a variety of sources, the computer uses nine separate screening methods to develop comprehensive physician profiles. These screens are listed in the Quality of Care diagram below.

Physician Quality of Care Monitoring Program



Managed Care

Provider Quality Of Care Monitoring Program

Intervention Process Triggered By Computer Analysis

If the computerized Quality of Care review results in a negative finding for a physician, the finding is assigned a numeric score that reflects its seriousness. Physicians with a total score greater than a defined threshold are subject to detailed review. This triggers the intervention process.

Whenever a physician is flagged for detailed review, all available data for the physician are assembled. The physician is then evaluated by Private Healthcare Systems' clinical review committee of nurses and physicians. Actions resulting from the review may include:

- Special handling and monitoring of the physician
- Gathering additional data on the physician
- Disenrolling the physician from the network

In addition to disenrolling physicians who fall outside of established practice patterns, Private Healthcare Systems also uses the Quality of Care Monitoring Program to fine tune the network during each contracting cycle. The exchange of information among the provider network database, the utilization management database and the claims databases allows the Medical Management System to produce complete practice profiles of all network physicians. This means that the network can be further refined during the contract renewal process.

The sophistication of the computer system combined with carefully developed analytic screens, make quality and cost-effective practice patterns *more* than just buzz words. The integrity of all our managed care products is backed by the Quality of Care Monitoring Program.



Managed Care

Provider Quality Of Care Monitoring Program

Hospital Quality And Cost Monitoring

We monitor network hospitals to ensure that they maintain high standards. They must continue to meet the rigorous criteria required for admission into our network. These criteria include the board certification of hospital physicians, the ratio of RNs to non-RNs and the hospital's responsiveness to emerging medical trends. In addition, we take a close look at:

- *The hospital's mortality rate* as reported by the federal Health Care Financing Administration (HCFA). We check to see if the hospital's mortality rate is in line with its case mix.
- *The readmission rates of the hospital.* High readmission rates may indicate a tendency to discharge patients too soon.
- *The appropriateness of admissions.*
- *Length-of-stay extensions.* A high number of length-of-stay extensions may indicate that hospital patients suffer from a high rate of complications.

Depending upon the nature of the results, the intervention process may include:

- Additional monitoring
- Gathering additional data on the hospital
- Choosing not to include the hospital in our network when the hospital contract comes up for renewal
- Disenrolling the hospital from the network

By setting and maintaining stringent standards, we continually refine our provider network to ensure that you and your employees get the best, most cost-effective providers available.

UTILIZATION MANAGEMENT (Continued)

■ Pre- and Post-Payment Claims Review

Pre-payment review

- Validate that hospital, physician and outpatient services claims are not in conflict with or exceeding pre-defined limits compared to claims previously adjudicated.

Our computer system automatically checks for duplicate payments or duplicate claims entered. Once these claims are entered, the system generates the remark -- suspect duplicate and gives the draft number.

-- Suspension or rejection of claims

Once it has been determined that a claim is a duplicate, it would be rejected with a specific remark code.

Post payment claims review

- Providers identified for review by referral, practice profiling or rebundling software.

When the Benefit Payment Office receives claims for specific dental services, chiropractic services and medical services, these claims are referred to the Head Office for review of eligible benefits.

■ Internal Retrospective Review

Clinical Decisions

All non-certifications for lack of medical necessity and all final length of stay determinations by any PHCS reviewer physician are reviewed by a PHCS (Assistant, Associate) Medical Director. The explanation of the clinical decision is detailed in a medical-legal document entered into the computer system.

- 10% of all clinical reviews by physicians are continuously randomly audited by PHCS (Assistant, Associate) Medical Director.
- 10% of all MD/MD phone recorded conversations are randomly audited with emphasis on diplomacy and negotiation skills, and conformance with company procedures and policies, in addition to clinical reasoning.
- Statistics regarding each physician's rate of certification, non-certification, length of stay savings, alterations in location of case, as well as individual productivity, are reviewed monthly.
- On non-certifications an ongoing daily review is conducted to be sure that an appeal has been offered to the physician directly by our physician. (In addition to written notice of appeal to physician, patient, and facility).

UTILIZATION MANAGEMENT (Continued)

- **Tracking and Reporting** for client and program management is extremely encompassing. It includes:

Tracking of utilization review outcome data annually for effectiveness

- Number of reviews
- Percent cases referred for physician review, appealed, overturned
- Average length of stay (ALOS) in days
- Change in ALOS from year to year
- Admissions/1000
- Outpatient procedures/1000

Tracking of mental health/chemical dependency utilization

- Number of days/1000
- Average adult, adolescent inpatient lengths of stay (days)
- Average number adult, adolescent outpatient psychotherapy visits per patient

Reporting cost and utilization experience, savings and other utilization management activities, as well as sharing information with employers and other purchasers and patients.

TOPIC: ALTERNATIVE MECHANISMS FOR PAYMENT TO PROVIDERS

- **Hospital payments**

Hospital payments are subject to audit review if certain criteria are met. Focus of the audit, prior to full payment, is to review for appropriateness of services billed and accuracy.

Through case management, patients are encouraged to use Centers of Excellence for transplants.

- **Non-Hospital payments**

By CPT-4 code, reasonable and customary cost levels are determined and up-dated in our claims system. Payments for most non-hospital based charges are controlled by these limits.

Edits for identifying potential billing problems exist in the claim system presently. These are continually being enhanced by in-house experts, as appropriate based on cost/benefit analysis and technological advancements.

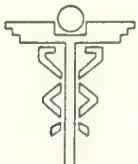
Managed Care

Advanced, Patient-Sensitive Health Care Review Service

Even the best managed care efforts can fail if services don't respond to the needs of individual patients. Managed care is most effective when patients view the utilization review and case management program as benefits that help them make difficult health care decisions. The Health Care Review Service is designed to protect patients from unnecessary procedures and to protect companies from incurring unnecessary medical costs. Our position is that the *best* care is the *right* care—the care that is most appropriate for each individual.

The Health Care Review Service uses criteria developed by health care experts to determine medical necessity. It is operated by doctors, nurses and specialists, so patients can be sure the review is conducted by well-qualified professionals. The Health Care Review Service incorporates database technology with case-by-case expert attention, making it the most sophisticated utilization review program available.

Patients Are Protected Throughout The Treatment Process



To ensure patients get the best, most appropriate care, the Health Care Review Service is comprised of four components:

- Utilization review
- Targeted concurrent review
- Hospital discharge planning
- Catastrophic case management

With these components fully integrated into our managed care programs, we ensure that patients are served by a comprehensive program that addresses the entire patient treatment process—*before, during and after* care is provided. It ensures that:

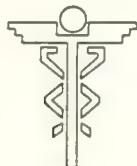
- The proposed treatment is in line with common practice
- The health care facility is equipped to provide necessary care
- The patient stays in the hospital only as long as necessary
- Employees get the maximum coverage available
- Treatment is provided on a cost-effective basis

And, because it's fully integrated with our administrative and claim processing services, it is convenient for you and your employees.

Managed Care

Health Care Review Service

Utilization Management Is Handled By Qualified Medical Professionals



With The Health Care Review Service, you and your employees can be confident that experienced medical practitioners are behind the design and day-to-day operation of the program. The doctors and nurses at Private Healthcare Systems make sure patients receive the most widely accepted, clinically appropriate care when they need it—and protect them from unnecessary treatment when they don't.

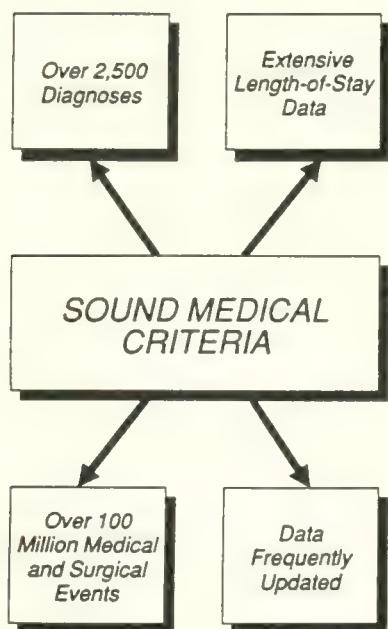
- Over 250 full-time registered nurses (RNs) are on staff to handle the utilization management program. All RNs have a minimum of three years clinical experience, and the average length of experience is eight years. Many come from hospital settings.
- All calls for pre-treatment authorization are handled by registered nurses, except for normal deliveries and a few outpatient surgical procedures. These are handled by more cost-efficient utilization review assistants.
- In addition to six full-time medical directors on staff, a 57-member physician advisory panel is available for consultation. All are board-certified, actively practicing physicians with a minimum of five years post-residency experience. The panel includes general practitioners, internal medicine physicians and a full range of specialists.
- The physician advisory panel handles special cases and evaluates medical necessity whenever a provider's recommendations fall outside normal practice patterns. Three to five members of the panel are on site daily.
- The physician advisory panel provides a built-in second opinion program. Physicians from the panel can consult with the patient's physician to discuss medical conditions and treatment options.
- Additional physicians from a wide range of sub-specialties are available for phone consultation on an as-needed basis.
- A separate group of mental health specialists handles psychiatric and substance abuse cases. A mental health specialist is assigned to review and coordinate treatment for each case.

The strength of our program is that it is medically driven, with a high proportion of registered nurses and physicians on staff.

Managed Care

Health Care Review Service

Comprehensive Medical Criteria Direct Utilization Management



Medical necessity criteria have been established to assist utilization management professionals in evaluating diagnoses, symptoms, clinical and diagnostic findings, and other factors specific to each individual case.

The medical criteria are built into a database so that comprehensive data is available at the reviewer's command. Because of the comprehensive database, utilization management professionals can deal with complex issues of medical necessity quickly and accurately:

- Specific criteria have been developed for more than 2,500 of the most frequent and costly diagnoses and surgical procedures.
- Over 100 million actual medical and surgical events have gone into the development of the medical criteria used to determine medical necessity.
- This database is constantly updated to incorporate medical breakthroughs and developing treatment guidelines for illnesses not yet fully understood, such as AIDS.
- The database also includes length-of-stay information that is drawn from the large volume of internal claims data and from trends in national claims data.
- Length-of-stay data is also reviewed and updated frequently, with the top 50 surgical procedures reviewed and updated quarterly.

Medical knowledge is not static, but constantly evolving. A large volume of medical data was used to develop this advanced database, and it is maintained with frequent and thorough updates. This keeps the system at the cutting edge.

Managed Care

Health Care Review Service

Utilization Review Process Is Convenient, Thorough and Patient-Sensitive

An important part of the Health Care Review Service is our *patient-sensitive* utilization review program. This review process is based on sound medical criteria and advanced computer technology; however, our main concern is to ensure that patients receive the best, most appropriate care. In effect, the program functions as a built-in second opinion to ensure that the proposed treatment and medical facility are appropriate and that patients won't undergo unnecessary procedures or spend unnecessary days in the hospital. By ensuring cost-effective and appropriate care, the program also saves money.

This telephone-based program is convenient for both patients and their providers. Each step of the utilization review process is described below.

Step 1: Provider Calls Health Care Review Service



*Provider Calls
Health Care Review Service*

We ask that the patient's physician call the Health Care Review Service for authorization of all surgical procedures performed outside the physician's office and for all hospital admissions. Authorization is required for both emergency and non-emergency treatment:

- ***Non-Emergency*** — The patient's physician is asked to call for pre-treatment authorization at least 7 days prior to hospitalization.
- ***Emergency*** — Under most plans, emergencies must be reported to the Health Care Review Service within 48 hours or the next working day (72 hours in some states).

So that pre-treatment authorization information is always at hand, a brief description of these requirements, along with the toll-free number for the Health Care Review Service, appears on the back of all employee ID cards. The complete review usually takes between 4 and 10 minutes, depending upon the complexity of the case.

To make the process easy for patients and to encourage the use of preferred providers (when available), we've done the following:

- If patients use hospitals or physicians in our network, they *never* have to worry about pre-treatment authorization. Network providers are responsible for obtaining authorization.
- If patients use non-network providers, they are responsible for making sure their physicians calls for authorization.

Managed Care

Health Care Review Service

Utilization Review Process (continued)



Step 2: Patient-Sensitive Evaluation

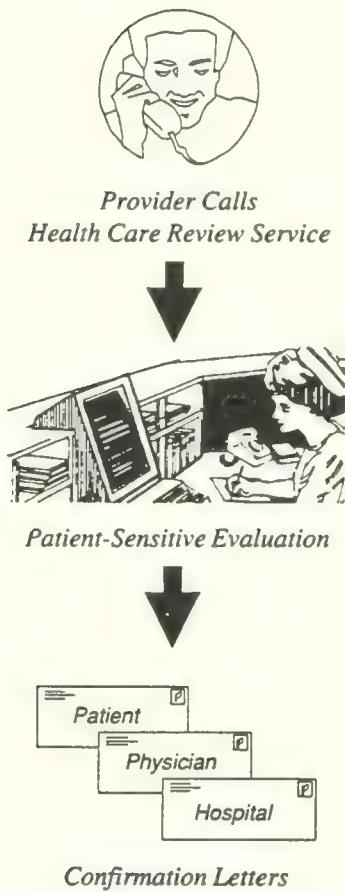
The utilization review process is telephone-based to make it as fast, convenient and effective as possible. Over the telephone, the medical reviewer can gather all the information needed to make a thorough assessment of the patient's condition. Not only does this eliminate time-consuming paperwork, but it allows for a dialogue between professionals. The patient-sensitive evaluation includes the following:

- When a provider calls the Health Care Review Service for pre-treatment authorization, a registered nurse gathers pertinent medical history and treatment plan information. The reviewer also gathers information on any special medical conditions or needs that could affect treatment decisions.
- The computer system recalls the patient's previous history of admissions and diagnoses, allowing the reviewer to assess the proposed treatment and individual needs more accurately.
- The recommended treatment is measured against current medical standards using a sophisticated computer program with criteria for over 2,500 diagnoses. Board-certified physicians and specialists are also on hand for additional consultation.
- If necessary, the patient or legal guardian may be called during the review process for additional case history information. The reviewer wants to make sure he/she is fully informed of each patient's special medical conditions.
- During utilization review, potentially large claims are identified through the use of extensive computerized diagnostic criteria, and patients are referred for case management at an early stage.
- A second opinion is built into the utilization review process because the patient's physician can discuss the diagnosis and treatment alternatives with a board-certified physician or specialist at Private Healthcare Systems.
- Depending upon the proposed treatment, discharge planning may also be done at this time. Cost-effective after-care facilities may be recommended as a more comfortable and appropriate alternative to extended hospital stays.

Managed Care

Health Care Review Service

Utilization Review Process (continued)



Step 2: Patient-Sensitive Evaluation (continued)

Based on all available information, the reviewer:

- Determines the medical necessity of the proposed treatment
- Makes sure the treatment location is appropriate
- Verifies that the proposed treatment is in line with currently accepted practice
- Assigns a length of stay for necessary hospital admissions
- Makes hospital discharge plans with the patient's physician, if appropriate

The reviewer uses a set of criteria developed by independent medical experts at Value Health Sciences (VHS) to screen for unnecessary or outmoded services.

If the patient is in our preferred provider plan, the reviewer can often redirect treatment to an appropriate network hospital by letting the physician know that the patient will receive higher benefits if a network hospital is used. This helps patients receive the highest benefits and the best value for their health care dollars.

If all criteria are met and the proposed treatment is confirmed, the reviewer gives the physician immediate verbal confirmation.

Step 3: Confirmation Letters Mailed Within 24 Hours

After treatment has been authorized over the telephone, written confirmation is mailed within 24 hours to:

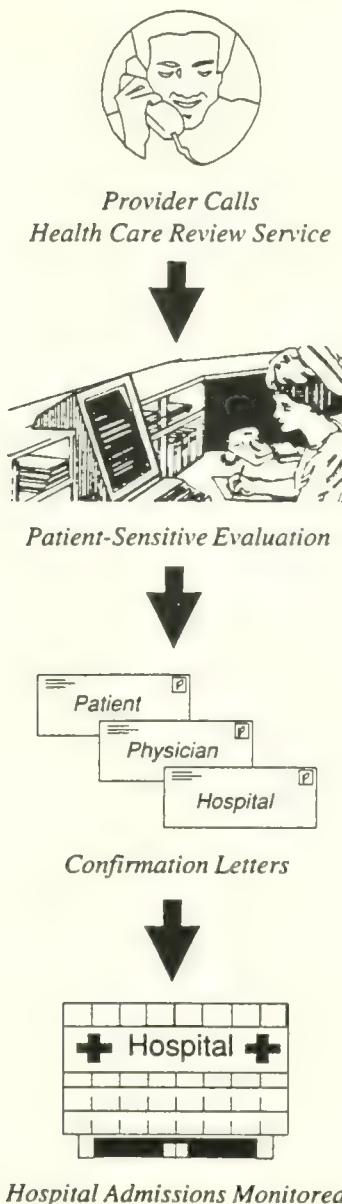
- The patient
- The physician
- The admitting hospital

If patients haven't received written authorization prior to hospitalization, they are encouraged to call the toll-free number on the back of their ID cards to check on their review status.

Managed Care

Health Care Review Service

Utilization Review Process (continued)



Step 4: Hospital Admissions Are Monitored

Targeted concurrent review is done for cases that merit ongoing monitoring of medical necessity and level of care. These include:

- Psychiatric or substance abuse cases. These cases are assigned to one of the mental health professionals at Private Healthcare Systems. This person monitors the case and coordinates the patient's treatment program.
- Cases in which a patient's physician has requested a rare or unusual procedure. In these cases, a registered nurse is assigned to manage the case from start to finish.
- Cases that are being monitored by our catastrophic case management program.

Routine hospital admissions are monitored through requests for length-of-stay extensions. Since a length of stay is assigned during the pre-treatment review process, the provider must call the Health Care Review Service if an extension is needed. At this time, the case is reviewed again. Based upon the patient's treatment needs, the reviewers may recommend a more comfortable and appropriate alternative to prolonged hospitalization. This could include an appropriate after-care facility or health care in the patient's home.

Hospital discharge planning is done so that patients won't have to spend unnecessary days in the hospital. The goals of discharge planning are to:

- Ensure that patients receive the quality of care they need in comfortable surroundings
- Keep treatment cost effective

Cost-effective after-care facilities may be recommended as an alternative to extended hospital stays. This may be done during pre-treatment authorization or when length-of-stay extensions are requested by the attending physician.

Managed Care

Health Care Review Service

Professional Handling Of Questioned Or Disputed Treatment



The professionals at Private Healthcare Systems make sure that patients receive the most cost-effective and appropriate care. Whenever clinical findings or proposed treatments do not meet established criteria, the case is automatically reviewed by a member of the physician advisory panel. This allows physician-to-physician consultation to determine the best treatment for that patient.

If the physician advisory board denies a treatment request, the patient may appeal the decision by securing an independent second medical opinion, which is usually paid for under the plan. The patient may call the Health Care Review Service for help in selecting an appropriate, qualified physician or specialist for a second opinion.

Our utilization review process gives patients peace of mind because:

- They know that proposed hospital treatments or surgeries are reviewed by qualified professionals.
- It helps them avoid needless hospital stays and the risks of unnecessary medical procedures, receive because the review functions as a built-in second opinion.
- They are protected—as are their employers—from incurring unnecessary costs.

Medical decisions are complex and medical practices are continually evolving. Your employees need to know that the medical professionals operating our Health Care Review Service provide a necessary safety net for patients.

Managed Care

Health Care Review Service

Catastrophic Case Management Helps Patients Plan Care

Our catastrophic case management program is designed to help patients who will need a great deal of medical care, potentially for the remainder of their lives. Such patients are faced with multiple treatment options that can affect the quality of their lives—and treatment will be very expensive.

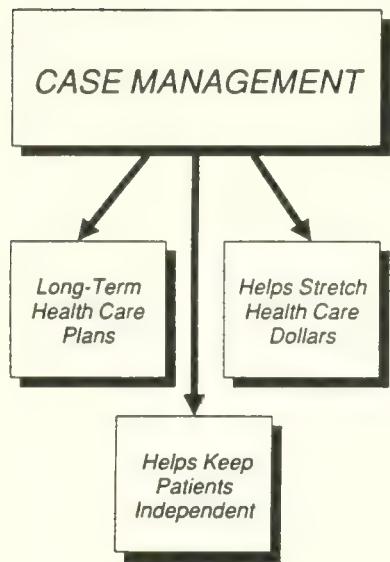
10% of individuals spend 70% of health care dollars; 1% account for 30% or more.

Although large claims aren't frequent, they account for a significant portion of total health claim costs. In fact, according to one recent study, about 10% of all individuals spend 70% of health care dollars, and 1% account for 30% or more. Since high-cost patients have a big impact on the cost of a company's health plan, it's important that the medical care for these patients be managed carefully.

Effective case management helps control high health care costs while ensuring that the patient receives the most appropriate care. Our case managers are trained to work with the patient, medical treatment team and family members to establish and carry out a comprehensive plan of care. Their goals are to:

- Develop a treatment plan that will provide high quality, patient-sensitive care
- Help stretch a patient's health care dollars throughout the course of the illness or disability
- Help the patient retain his/her quality of life and independence for as long as possible

The results of this program are beneficial to the patients and to their employers. By saving money and providing real help to patients with a catastrophic illness or disability, case management benefits everyone concerned.



Managed Care

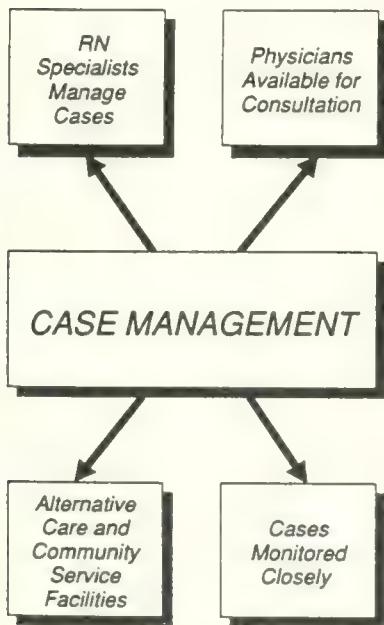
Health Care Review Service

Catastrophic Cases Are Identified Early

Case management is most effective when patients with a catastrophic illness or injury are identified early and become involved in the case management program as soon as possible. We have two ways to identify catastrophic cases:

- During the utilization review process, patients are identified and referred for case management at an early stage through the use of extensive computerized diagnostic criteria. They may also be identified through repeated re-admissions or length-of-stay extensions.
- Our benefit examiners in each benefit payment office are trained to identify potential catastrophic cases based on diagnosis and dollar expenditure thresholds. Such cases are then referred for case management.

Key Assets Of Our Catastrophic Case Management Program



Here are the key assets of our patient-sensitive case management program:

- Case managers are all registered nurses with different areas of specialization (e.g., pediatrics, surgery, AIDS).
- Case managers consult with board-certified physicians.
- Case managers have access to a list of diverse alternative care and community services that are available in major metropolitan areas. These computerized lists are updated continually.
- Cases are monitored closely and treatment plans adjusted to meet the patient's needs and desires.

While participation in the program is strictly voluntary, case management offers patients better continuity and coordination of care. Case managers help coordinate services and recommend cost-efficient, quality alternatives to prolonged acute care hospitalizations.

On average, case management saves \$3.50 for every \$1.00 spent on the program. So, while patients receive better continuity and coordination of care, advance planning also keeps costs down. But the program does *more* than save money. It provides patient-sensitive solutions that help these patients improve their quality of life.

■ Payment submission

We presently subscribe to a number of organizations, such as NEIC, in order to obtain hospital and physician claims electronically. These are received automatically in our payment system.

TOPIC: THIRD PARTY LIABILITY/COORDINATION OF BENEFITS

- Data matches to other organizations and insurers that capture relevant data (e.g., Workers Compensation, auto insurance, CHAMPUS)

--not applicable--

- Cost avoidance processing through review of external databases, e.g., (auto insurance, child support enforcement, state retirement system, etc.)

--not applicable--

- Calculation of average savings to cost ratios to determine cost-effectiveness of Third Party Liability/Coordination of Benefits activities

--not applicable--

What we do is track the percentage of savings to total claims paid. In 1993, total saved for total COB excluding Medicare was 2.71%. Total saved for Medicare was 3.31%.

■ Coordination of benefits

- Cost-effective update of COB information files

We have COB with any and all primary carriers by acquiring a copy of their EOBs and a copy of the original bill.

- Timely response to customer inquiry

Telephone inquiries are handled on a priority basis. Goal will be to respond within 24 hours.

- Timely claims processing

Our goals for the Benefit Payment Office turnaround time is set at 10 days. If a claim requires Head Office review, the response is handled on a turnaround time of 5 days.

- Cost benefit analysis
--not applicable--

- Other innovative strategies in other party liability that address accuracy in claims payment, uniformity, and reduction in costs and administrative burden

Customary charges are determined for a particular area by using a national survey to which many other insurance companies pool expense information. Our computer data is updated every 6 months. All areas of this Company utilize industry wide data when assessing payments, uniformity and administrative procedures.

TOPIC: ADMINISTRATIVE METHODS

- Acceptance of standardized claims formats

- HCFA 1500, Health Insurance Claim Form for medical claims

Standardly accepted.

- HCFA 1450 (aka UB-82, UB-92) Universal Billing Form for hospital claims

Standardly accepted.

- Universal Billing Form (NCPDP-approved) for pharmacy claims

Standardly accepted.

- ADA Dental Form for dental claims

Standardly accepted.

ADMINISTRATIVE METHODS (Continued)

■ Collection of information to support a unified data base

- . Acceptance of specific patient and provider identification numbers

Standardly accepted.

- . Move to provider acceptance of standardized remittance advice formats

Standardly accepted.

- . Move to accept standardized Explanation of Benefits (EOB) formats

Standardly accepted.

- . Move to accept common local coding requirements

Standardly accepted.

- . Accept local field indicators

Standardly accepted.

- . Incorporate system edits/audits to validate procedure and diagnosis appropriateness and provider qualifications

We have incorporated an audit system to validate procedure and diagnosis appropriateness and provider qualifications

■ Acceptance of common coding schemes

- . CPT--Common Procedural Terminology
- . HCFA--Common Procedure Coding System (HCPCS)
- . National Drug Codes (NDCs)
- . ICD-9-CM--International Classification of Diseases, 9th Revision, 4th Edition, Clinical Modification, Procedure and Diagnosis Codes
- . DSM III - R--Diagnostic and Statistical Manual III - Revised
- . ADA Dental Procedure Codes, Tooth codes, and Surface Codes
- . Revenue Center Codes

All of the above common coding schemes are accepted and used.

- Move to adopt Workgroup on Electronic Data Interface (WEDI), or other national efforts towards electronic standardized formats
 - . Enrollment
 - . Eligibility
 - . Claims submission
 - Payment and Remittance advice

We will accept Workgroup on Electronic Data Interface (WEDI).

- Procedures to conduct internal performance monitoring

- . Ongoing review of administrative costs --
- . Responsiveness to patients and providers during claims processing and appeals processes
 - Timeliness

We have set goals for turnaround time for actual claims and telephone inquiries.

- Responsiveness

We have set goals for responding both written and verbally to plan participants and providers of service.

- . Measurable claims processing performance standards
 - Timeliness

We have set goals for turnaround time.

- Quality

We have Quality Assurance Procedures in place.

- Accuracy

We have an internal audit program in place.

- Pricing?

For those preferred providers who accept a scheduled benefit amount, these allowances are based on other markets. All non-scheduled allowances are processed in accordance with national survey data.

■ Other Innovative Strategies, Qualitivty 94 Program

- . This program rewards our Benefit Payment Offices by monitoring claim payment turnaround time, customer service, and productivity.

TOPIC: ANTI-FRAUD

Strategies: The features of our program are as follows:

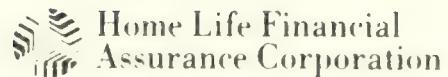
Prevention and Detection:

- as part of our training of new benefit examiners, a unit on fraud and its detection is included;
- ongoing training of experienced benefit examiners on the subject of fraud;
- the benefit examiners are provided with detailed instructions in their claims manual for handling potential fraud claims;
- once a fraudulent provider is identified, he or she is "flagged" in our computer system; the "flag" type indicates that special handling is required for that particular provider;
- can provide information on the reverse side of our Explanation of Benefits regarding potential fraud situations; these messages can be changed approximately every 6 months to address different concerns;
- providing assistance to our clients (policyholders) in educating their employees. Upon request, we will help the client draft wording as "payroll stuffers" to provide to their employees regarding potential fraudulent claims.

Follow up Procedures:

- manual guidelines provide the benefit examiners with procedures for pursuing situations where fraud has been identified;
- the Quality Assurance Department in Head Office has responsibility for assisting the benefit examiner in situations involving fraud;
- the Loss Prevention Department in Head Office has as its primary function pursuit of certain fraudulent situations in conjunction with our Law Department.

Charlotte A. Furman, FLM
Vice President-Group Marketing &
Compliance



March 16, 1994

Mr. Michael Craig
Director of Planning and Research
Montana Health Care Authority
Capitol Station
Helena, MT 59620

RE: Cost Management Plans - Your Memorandum of January 7, 1994

Dear Mike:

I am pleased to enclose the plan data requested in your January 7th memo. Thank you for granting us an extension of time in which to submit this material to you.

Montana is not a state in which we are actively marketing to any great extent. We therefore do not cover a significant number of the residents of your state, nor do we have any policies and procedures in place which have been developed specifically for Montana.

You will note that the attached Cost Management Plan material starts with Topic/Area Three. The reason is that we do not yet have in place any Integrated Systems for Health Care Delivery nor for Quality Improvement and Assessment. We have recently launched a project that will result in our developing and implementing such strategies and systems on a nationwide basis in selected target markets over the next couple of years. However, at this point, it would be much too premature to attempt to report on these discussions.

As you review our Plan for the other areas, any missing numbered items indicates that we have nothing in place for that particular strategy.

Thank you again for extending the March 1st deadline for us. If you need any additional information or have any questions on any of the enclosures, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink that reads "Charlotte". Below the signature, the initials ":slm" are written.

Enclosures

COST MANAGEMENT PLANS

Topic/Area Three: Utilization Management

12. Case Management

Initiated as a result of direct referral from the Utilization Review staff. Upon notification to the Utilization Review staff of a catastrophic injury or serious illness all pertinent information is referred to the Medical Case Management staff for assessment. The Medical Case Management staff will assess the appropriateness of care, review possible alternatives, and present recommendations or suggestions to family, patient, and physician. The Medical Case Manager will continue to work closely with all parties involved to assure that patients receive the most appropriate care at appropriate cost levels.

13. Pre-Admission Review

Performed prior to hospitalization to determine the need for admission, the appropriate level of service and to identify potential problems and determine possible solutions regarding the admission.

Admission Review

Performed to ascertain that an emergency admission meets approved criteria and to identify discharge planning needs. For Pre-Admission review and admission review the patient, hospital and physician are notified by letter within two working days of receipt of the necessary information.

Re-Admission Review

Performed for all medical and surgical re-admission within fourteen day period. Re-admission with the same diagnosis are screened for complications or incomplete management of problems on the previous admission.

The Appeals Process

For adverse decisions resulting from the pre-admission or admission review process, an appeal can be initiated by the attending physician or the patient. An expedited appeal or telephonic appeal within 24 hours can be requested or the appeal can go through the standard level of appeal. The standard level of appeal is made in writing within 30 days. Whenever possible the review will be done by a physician of the same specialty who has not had prior association with the case.

14. Concurrent Review

Performed telephonically to ensure that any hospital stay beyond the estimated length of stay is medically necessary, at the appropriate level of care and that discharge planning needs are being assessed. When screening criteria are no longer met and there is no plan for discharge within 24 hours, the case will be referred to a Physician Advisor.

The appeals process for adverse determinations for concurrent review is the same as described in #12.

15. Discharge Planning

An integral part of the Utilization Review process. Upon certification of an inpatient admission, the Utilization Review Nurse will begin assessing the patient for discharge needs, if any.

The role of the Nurse Reviewer is to identify possible post hospital health care needs of the patient and forward this information to the appropriate MCM personnel.

Discharge begins during preadmission review and continues throughout the Utilization process. Discharge involves the physician, the physician's office staff, the hospital's Discharge Planning personnel and the family.

The Medical Case Management staff member will determine if any needs have been identified, if physician's orders have been given, and if Home Care agency has been contacted.

16. Outpatient Utilization Review

Performed to balance patient care quality, safety and cost effectiveness. Services are reviewed to determine the benefit to the patient and to rule out services that would place him at risk.

All procedures on the Trigger list are reviewed by a nurse reviewer prior to authorization. (For example: MRI, Lyme Disease, Home Health Care, Physical Therapy, Arteriogram).

Review of the outpatient surgeries that are frequently performed are reviewed by nurse reviewers. (For example: Cataract Removal, D&C, Stripping & litigation of varicose veins).

The patient or his/her physician may appeal an adverse determination in writing within 30 days.

17. Pre- and Post-Payment Claims Review

Our claims payment system is integrated with the utilization review data base. It provides a warning message to the claims processor to identify hospital/physician charges that exceed authorized levels.

We do not have automated mechanisms in place, however, claims processors have been trained to identify adherent billing practices and patterns.

18. Internal Retrospective Review

Performed by the Quality Assurance Coordinator to enhance and maintain the quality of inpatient and outpatient reviews and to maximize the quality and appropriateness of staff performance. To monitor the quality of services provided, internal audits on a random sample of prospective, concurrent and outpatient files are performed on a monthly basis.

20. Utilization Management Tracking

To determine if utilization management strategies are effective and should be continued or modified.

Tracking Includes: Number of Reviews

Percent of cases referred for physician review, appealed, overturned

Average length of stay (ALOS) in days

Change in ALOS from year to year

Admissions/1000

Outpatient procedures/1000

Tracking of mental health/chemical dependency utilization:

Number of days/1000

Average length of stay in days

Charge in ALOS from year to year

21. Better Infant Beginnings (BIBS)

A special service we provide to employees and dependents to employees and dependents covered under any of our medical plans. BIBS is designed to assist the mother-to-be in having a safe pregnancy and delivering a healthy baby.

Program goals are to provide all pregnant employees/dependents with prenatal education and toll-free access to the BIBS nursing staff. It also provides suggestions and assistance to mothers and families who face the possibility of a high-risk pregnancy.

Better Infant Beginnings (BIBS) cont'd

To determine High-Risk pregnancy, it is requested that women notify us as soon as they learn they are pregnant. A nurse reviewer will arrange a telephone health screening. This screening helps to identify possible pregnancy complications.

Medical Case Management will assist with coordination and monitoring of Home Care needs.

Topic/Area Four: Alternative Mechanisms for Payment to Providers

22. Hospital Payment

For hospital reimbursement we do not have global mechanisms in place for Montana, however we do negotiate with facilities and or agencies on specific potential high dollar claim situations.

23. Professional Payment

For Professional reimbursement we utilize Home Life Financial Assurance Corporation guidelines for the determination of global packages. We utilize of the profiles provided through HIAA to determine reasonable and customary reimbursement levels.

24. Outpatient Hospital Services

Outpatient claims are reviewed by examiners to determine if charges appear consistent with the procedure performed. Claims considered as outliers are audited by in house staff and/or outside vendors.

25. Durable Medical Equipment

We have several national contracts with durable medical equipment and medical supplies for discounts. We also have national contracts for both pharmacy and mail prescription services.

Topic/Area Five: Third Party Liability/Coordination of Benefits

31. Coordination of Benefits

We update our member records during enrollment and annually thereafter to maintain COB information. Claims involving COB are processed promptly upon receipt of the primary carriers statements. A national analysis of COB savings is performed on a monthly basis. We participate in the MEDICARE/MEDICAID data match program.

32. Third Party Liability

Home Life Financial Assurance Corporation has a contract provision which states a third party may be liable or legally responsible for expenses incurred by an insured for an injury or a sickness. Benefits may also be payable under the Health Care Coverages under the Plan for these expenses. When this happens, we may, at our option, recover from the insured any benefits paid under the Health Care Coverages which the insured is entitled to receive from the third party. We will have a first lien upon any recovery whether by settlement, judgement or otherwise, that the insured receives from the third party's insurer or guarantor or; any uninsured motorist insurance. This lien will be for the amount of benefits paid by us for Medical Care of the injury or sickness for which the third party is liable or legally responsible. If the insured makes any recovery as set forth in this provision, and fails to repay us fully for any benefits paid under this provision, then the insured will be personally liable to us to the extent of the recovery up to the amount of the first lien. The insured must cooperate fully with us in claiming our rights of recovery.

The claims examiner identifies any claims which might be a candidate for this type of recovery, based on guidelines which have been provided. Before any benefits are paid by us, we require the insured to provide all information and sign and return all documents necessary to carry our rights under this provision. Once we have reviewed the documents back, the claims are released and all information is forwarded to our technical area for the purpose of monitoring the monies released and to monitor all legal activity in order to recover all monies paid.

Topic/Area Six: Administrative Methods

33. Acceptance of Standardized Claim Forms

We accept ADA, HFCA 1500, UB82, and UB92 universal billing forms.

34. Collection of Information to Support a Unified Database

Our explanation of benefits format is consistent with national and state standards.

35. Acceptance of Common Coding Schemes

We accept CPT, ICD9-CM, DSM III and ADA coding schemes.

36. Workgroup on Electronic Data Interface (WEDI)

We are moving to adopt WEDI electronic standardized formats for eligibility, claims submission and payment remittance.

Topic/Area Seven: Anti-Fraud Efforts

39. Fraud and Abuse Controls

Home Life Financial Assurance Corporation is committed to containing the spiraling cost of health care by identifying and preventing fraud and abuse in the filing of health claims.

The Special Investigation Unit (SIU) keeps abreast of current trends in fraud and abuse by attending conferences, such as those offered by the National Health Care Anti-Fraud Association and the Eastern Claims Conferences. These conferences are instrumental in obtaining up to date information, learning about the availability of resources and actively networking with other health insurers.

The S.I.U. develops guidelines and performs training for Benefit Operations. A quarterly "Fraud Alert" newsletter is distributed to claims personnel. Training sessions are conducted for various departments, i.e. claims, customer service, quality review and pre-treatment review to educate new staff. Various resources are used, including video tapes and information obtained from the news media.

A monthly publication to our policyholders, On the Homefront, is a tool used for educating our clients. Our customer service toll free number is available for the reporting of suspected fraudulent situations. Comments on EOB's encourage clients to report any discrepancies. We are currently developing a reward system for fraud reporting, which will encourage client participation in our efforts.

The S.I.U.'s primary focus in fraud detection and prevention, has been in identifying claim's submitted for services not rendered and claims submitted with false diagnosis or data. Suspect health care providers are "flagged" in our computer system, which prevents claim payment without supervisor review and/or SIU referral. An information screen exists in our computer for each flagged providers and it may contain certain criteria for claim consideration. Upon referral of a claim to SIU medical records are obtained. If necessary, verification of services is requested from the patient. This information is analyzed by SIU. Frequently there is input by the medical director or an independent reviewer. Both the provider and the client are notified of our findings and the resultant claim determination. This serves the dual purpose of alerting the provider and educating the client that we consider it our responsibility to deter and eliminate false claims that drain the system.

Once a pattern of fraud or abuse has been established, the appropriate professional, governmental or law enforcement agency is notified. Prosecution is pursued with the approval of the legal department.

Fraud and Abuse Controls cont'd

A management report is prepared monthly on the savings attributed to special investigations intervention.

37. Procedures to Conduct Internal Performance Monitoring

We have internal standards in place for ongoing reviewing of turn around, administrative costs, claim time, and customer service response time. We comply with state and ERISA standards for responses to appeals. These activities are monitored on a daily basis as well as claims accuracy and quality.

HORACE MANN
COST MANAGEMENT PLANS

Topic/Area Three: Utilization Management

Our utilization review program includes preadmission review, concurrent review and discharge planning. Scheduled hospital stays must be pre-certified five working days prior to admission. Emergency admissions must be pre-certified within 48 hours or the next working day. Hospital confinements are monitored for appropriateness of continued stay. Physicians review any denial of inpatient days. There is an appeal process in place to address denials. The program is telephonic; there is no on site review done.

Horace Mann Life Insurance Company has a dedicated unit to handle case management activities. The unit is responsible for identifying potential catastrophic cases. The staff coordinates communication and activity between the patient, family, health care providers and claims payor to assure quality care is received in the most cost effective, medically appropriate manner. In some cases on site evaluation and follow up is done by medical professionals.

We do not require pre-certification of out patient treatments or procedures. Benefit plans may require specified procedures be performed on an outpatient basis; specified procedures may also require a second opinion. Benefit plans may provide incentives to use alternatives to hospital emergency facilities for non life or health threatening illnesses and injuries.

The claims examiners receive extensive training in evaluating claims for appropriate coding by providers. Providers with questionable billing practices who are under state or federal disciplinary action are flagged on the claim system for automatic referral for further investigation prior to payment. We do not use "unbundling" or "rebundling" software. When claim benefits exceed a specified amount, our claim system "pends" the claim for management review and approval.

All claim drafts in excess of \$10,000 require review and signature by an authorized officer of the company. We have a quality assurance program in place to monitor claim processing accuracy.

The drug card program administered by Pharmaceutical Card System (PCS) checks for unusually high or low drug dosages, drugs inappropriate for the patient's age, drug interactions, drugs inappropriate during pregnancy and drug duplication or excessive usage. The pharmacists in the PCS network assist the insureds with information and problem resolution. We do not perform analysis or utilization patterns.

Our utilization review vendor has a program to monitor quality, accuracy and consistency of utilization review decisions.

Quarterly, our utilization review firm provides detailed reports on a group basis showing admissions per 1,000, days per 1,000, average length of stay by diagnosis and surgical procedure and a provider profile of hospitals used during the reporting period.

We do not currently perform provider profiling or outcomes research.

Topic/Area Seven: Anti Fraud

We have established guidelines used by the claims examiners to identify potential fraudulent claims and providers. When billing discrepancies are verified, we refer the case to our legal department for further handling. When appropriate, we refer cases to the postal authorities, state or federal agencies for prosecution. We also have a special investigative unit in-house. We use various state and federal disciplinary reports to help identify providers with questionable billing practices.

Results of potential fraud cases are monitored and reported quarterly.

Topic/Area Six: Administrative Methods

We accept standardized claim forms including HCFA 1500, UB82 and UB92, Universal billing and ADA. We capture patient and provider identification numbers.

We use these common coding methods in our claims processing activity - CPT, ICD-9-CM, DSMIII-R, as well as specific service codes for different types of treatment expenses.

We do not currently have electronic claim capability. However, we are interested in pursuing this technology and participate in the workgroup for Electronic Data Interchange.

We have developed corporate service standards for claims processing timeliness and accuracy. We also have corporate standards for responses to customer phone calls and correspondence. Performance is monitored and reported monthly. Quarterly review sessions are held with the senior officers of the company. We monitor all insurance department complaints and send out customer satisfaction surveys monthly.

Topic/Area Five: Third Party Liability/Coordination of Benefit

We use completed claim forms and information from providers to identify coordination of benefit cases.

In some cases we contact the spouse's/dependent's employer to verify other insurance. We do not use external databases to accomplish this. When we determine there is other coverage, right of reimbursement potential or Worker's Compensation, we enter this information on the claims system to flag future claims for investigation.

COB savings and third party liability recoveries are monitored monthly. Results are compared to industry norms to determine effectiveness of our programs.

Topic/Area One: Integrated Systems for Health Care Delivery Strategies

Our group health plans may include benefits for preventive care services. Typically this type of benefit is included at the employers direction.

We encourage use of the most appropriate level of care i.e., out patient facilities, skilled nursing, home health care, hospice, birthing clinics and emergency care centers in lieu of inpatient hospital confinement whenever medically feasible. The health plan may include benefit incentives to promote the use of these alternate treatment sites. A sample of employee educational materials is attached.

We have a program available which provides reduced pharmacy costs through a drug card program administered by Pharmaceutical Card System (PCS). Also, there are cost savings when insureds use the Home Pharmacy program. This provides delivery of prescriptions for chronic illnesses to the insured's home. Generally they are given a three month supply at a reduced cost.

We currently participate in the Beech Street preferred provider network in Montana. We have not developed our own provider networks.

Topic/Area Two: Quality Improvement and Assessment

We do not currently perform provider profiling or outcomes research.

We participate in the United Resource Network program for organ transplant cases. They monitor quality of care, outcomes and patient satisfaction at the participating facilities. They've established criteria for selection of their centers of excellence for each type of transplant.

Topic/Area Four: Alternative Mechanisms for Payment to Providers Strategies

Our health plans provide benefit only for medically necessary treatment of illness and injury. The plan may include benefit incentives to use non hospital emergency rooms for treatment of non life threatening conditions. These incentives include deductible waiver and benefit percentage differential.

As stated previously we participate in the United Resource Network for organ transplant cases. They've established centers of excellence for each type of transplant. We realize benefit savings through this network. We also participate in the Pharmaceutical Card System program which provides reduced costs for prescription drugs. In addition, we use Olsten-Kimberly Care for home care services and medical supplies at reduced cost. In some cases we negotiate directly with providers for discounted reimbursement levels.



MAILING ADDRESS
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Sacramento, CA 95865-9002
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John Alden®
LIFE INSURANCE COMPANY

RECEIVED

157-1 1994

To: Montana Health Care Authority
ATTN: Mike Craig
P.O. Box 200901
Helena, MT 59620-0901

From: Hank Frantz, Vice President of Actuary
John Alden Life Insurance Company

Date: March 10, 1994

RE: Montana Cost Management Plan

Attached, in response to the questions submitted by the Authority, is the John Alden Life Insurance Company Cost Management Plan for the State of Montana. We have followed the area and question numbers outlined in the "Guideline for Insurer Cost Management Plans."

We look forward to continuing to be a major player in the small group insurance business in the State of Montana. If you have any questions regarding our Cost Management Plan, please feel free to contact me at (916) 565-5810.

John Alden Life Insurance Company

Proposed Cost Management Plan For the State of Montana

Overview

John Alden Life Insurance Company (JALIC) is engaged in significant activity in many of the areas touched on in the 40 questions posed by the Montana Health Care Authority. Many areas can be addressed by JALIC independently of the medical delivery system and can be addressed globally rather than locally. For example, we already have in place significant national processes in four of the seven areas, including:

- | | |
|--------|--|
| Area 3 | Utilization Management |
| Area 5 | Third Party Liability/Coordination of Benefits (COB) |
| Area 6 | Administrative Methods - Cost/Effective |
| Area 7 | Anti-Fraud Efforts |

The other three areas identified by the authority require that we form a business partnership with the provider community. So, implementation of a cost management plan is necessarily piecemeal and local. At this point in time, JALIC does not have access to PPO networks in Montana, nor the kind of business relationships needed to help build integrated delivery systems, quality improvement programs or alternative payment mechanisms.

We believe that a health insurer's role in the delivery of medical care will drastically change over the next 3 to 5 years. JALIC, for example, currently has a respectable share of the small employer market in many of the 47 states in which it operates. We believe that the future lies in our ability to compete in selected markets where we identify suitable health care providers who will join with us in obtaining a significant market share. We currently believe that a 20 percent market share is the "critical mass" that we must achieve in order to be a long-term participant in a market.

We currently have not identified suitable provider partners in Montana to achieve such market share. Unless suitable opportunities emerge, we will only introduce products in Montana that will be viable without the active cooperation of Montana health care providers. Such products will have a lower priority than the products we will introduce in target markets.

Priority Levels for Areas of the Montana Cost Management Plan

The following categories will be used to describe JALIC's current status in regard to specific questions asked by the Authority:

- Priority 1 Currently being done as a part of Cost Management and we expect to continue to evolve the process.
- Priority 2 Resources have been committed and we are actively working to incorporate this activity into our Cost Management program over the next twelve months.
- Priority 3 We are considering whether or not to invest resources in this activity.
- Priority 4 We have no current plans to engage in this activity.

Area One: Integrated Systems for Health Care Delivery (Questions 1 Through 6)

Introduction and Priority Levels

JALIC will become part of an integrated health care delivery system on a targeted basis. Nationally that effort has priority level 2, while in Montana the priority level is 4.

Several of the questions in this Area are covered in more detail in other areas and are answered there. For questions 4, 5 and 6, see Areas II and III.

For activities included in the other questions the following priority levels apply:

Question 1

Gatekeeper Plans	Nationwide-2	Montana-4
Preventive Services	Nationwide-1	Montana-1

Question 2

Discounts to encourage healthy lifestyle	Nationwide-4	Montana-4
Educational materials	Nationwide-3	Montana-3

Question 3

Point of service option	Nationwide-2	Montana-4
Other activities	Nationwide-1	Montana-1

Question 1 Benefit Packages that Promote Managed Care

Preferred provider plans tend to promote coordinated care through toll free customer service numbers and directories of providers which indicate specialties offered by physicians and other practitioners. Our new generation of products, which will be introduced in selected markets beginning in the first quarter of 1994, will include the "gatekeeper" or "primary care physician (PCP)" concept that will strongly encourage, and in some plan designs require, that the patient access the medical care system through his or her PCP.

Preventive care packages are included in current plans, and enhanced preventive care packages will be included in PCP plans and in selected other PPO plans.

PCP plans will only be offered, initially, in targeted markets where JALIC has a strong business relationship with appropriate providers.

JALIC currently has no PPO plans in Montana. Until an appropriate opportunity arises, we will not introduce PPO or PCP plans in Montana.

Question 2 Benefit Packages that Include Health Promotion and Promote Health Education

Such packages will be included in targeted markets. Wellness packages would have a low priority outside of target markets, unless we identify a vendor who could provide a package for us to offer with our plans.

There are no current plans to add this kind of benefit to Montana plans.

We believe that non-smoker discounts have a negligible impact on behavior. If people are willing to stand outside in the cold Montana weather to indulge their habit, how much impact would a non-smoker discount have?

Question 3 Flexible Benefit Plans that Promote Cost-effective Services

We routinely authorize non-covered services, if they are effective as, and more economical than, covered services. We have business relationships with many home health care companies. In general, JALIC's case management process, working in partnership with the attending physician, will always seek to maximize the effectiveness of care in the most cost-effective manner, no matter the contract language, treatment modality, or patient setting.

Area Two: Quality Improvement and Assessment (Questions 7 Through 10)

Introduction and Priority Levels

Through 1993 we have relied on PPO's to include in the network health care providers that meet standards developed by the PPO, which normally included a quality component. We will continue to rely on PPO's in many regional markets to perform that function. Occasionally we have contracted directly with providers who had good reputations, again relying mostly on the opinions of others. We are currently investing in technology and professional staff, and are forming partnerships with appropriate consultants and health care providers to define and measure quality. We are engaged in significant activity in the area of quality improvement and assessment strategies. These newly acquired skills will be used primarily in target markets.

Area II Priority Levels

Nationwide-2

Montana-4

Question 7 Contracting with Providers with Quality Improvement and Assessment Processes in Place that Reflect Continuity of Care, Coordination of Care, Minimizing of Patient Risk, and Continuous Quality Improvement

Question 8 Collection of Data on Efficiency, Quality and Patient Demographics and Health Status to Support Evaluative Functions and Outcomes Research

Question 9 Use of Provider Profiling Results in Development of Quality Improvement and Assessment Features

Question 10 Other Quality Improvement and Assessment Strategies

Response to Questions 7 Through 10

JALIC recognizes the importance of quality improvement and assessment activities. We are continually working to enhance our abilities to assess and improve quality of care.

- JALIC obtains clinical input from our Medical Director, and has recently hired an expert in the field to refine and expand our provider assessment program.
- JALIC analysts have extensive health care industry experience. They understand the dynamics of the health care industry, its data anomalies and contexts. Our analysts have capabilities to develop custom ad hoc reports to answer questions that may arise.

- JALIC is involved in provider assessment direction setting. For example, we are a member of the Health Plan Employer Data and Information Set (HEDIS) user's group.

Our provider assessment activities bring to bear many tools and information sources.

- JALIC is currently engaged in quality assessment and improvement activities which include the use of commercially obtained software, and programs written by JALIC staff. Some of these programs incorporate and codify medical criteria which allow screening of appropriateness of levels and amounts of care.
- On the JALIC provider file, there are flags which indicate, for each provider in our network, whether there are clinical or other business reasons that we might not want to contract with that practitioner.
- JALIC maintains high quality, "scrubbed" databases of paid claims and other demographic, financial, and administrative data. The quality of our database allows us to perform analyses accurately and efficiently, as well as to develop norms and standards.
- JALIC's analyses are based not only on our own database, but also on external sources of data and knowledge. Accessing national, state, regional, clinical, theoretical, academic and other standards and guidelines lends validity to our analyses.
- JALIC is working collaboratively with several software vendors to adapt and build upon their software so that it can support our efforts of quality assessment and improvement.
- JALIC is involved in collaborative processes with PPOs, HMOs, EPOs, PHOs and other managed care organizations in various markets to determine optimal ways of performing quality assessment and improvement.
- We also recognize that the state of the art of quality assessment is rapidly advancing. Therefore, we devote significant resources to keep current with new and improved processes and techniques. We continually educate ourselves with current academic, clinical and business literature and seminars so we may address provider assessment issues proactively.
- The overlapping dimensions of provider assessment include the following:
 - cost-effectiveness
 - quality of care
 - access analyses
 - patient satisfaction surveys

Examples of some of the measures that support our assessment activities include the following:

Quality Assessment Measures - Is the care that is provided of good quality and is it appropriate?

- Preventive services
- Continuity of care
- Coordination of care

Re-admission rates
Complication rates
National Committee on Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) measures
Clinical outcomes analyses
Disenrollment rates
Degree of upcoding
Degree of unbundling
Incidence of double billing
Inappropriate use of assistant surgeons
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation
Medicare certification
C-section rates
Hysterectomy rates
Vaginal Birth After Cesarean Section Rate (VBAC)
Presence of "sentinel" events

Cost-effectiveness Measures - Are we using efficient providers?

Overall network evaluation
 Out of network usage
 Length of stay
 Charges analyzes
 Excessive use of certain procedures

Individual provider profiles
 Average lengths of stay
 Charges analyses
 Excessive use of certain procedures
 Billing practices
 Comparison to other doctors

Access/Capacity Measures - Does our network provide adequate access to services?

Geographic location
Provider staffing ratios
Provider capacity
NCQA HEDIS measures
Provider qualifications (including Board certification/eligibility)

Area Three: Utilization Management (Questions 11 Through 21)

Introduction and Priority Levels

This area is a mixture of activities JALIC has engaged in for some time and activities that are in an embryonic status.

We view questions 11 (provider profiling) and 20 (utilization measurement) as part of quality improvement and assessment strategies. Priority Levels are as follows:

Question 11	Nationwide-2	Montana-4
Question 20	Nationwide-2	Montana-4

We have significant resources devoted to the other activities. Priority Levels are:

Questions 12 to 19	Nationwide-1	Montana-1
Question 21	Nationwide-1	Montana-1

Question 11 Provider Profiling to Determine Utilization Trends and Service Delivery Patterns

Question 20 Utilization Management Tracking

Response to Questions 11 and 20

JALIC performs provider profiling through which it examines utilization trends and delivery patterns. Our examination of utilization trends overlaps with the techniques and results of our quality assessment programs, both in method and in results.

Much of the information that is pulled together and the techniques that are used for the purposes of quality improvement and assessment are also used to help manage utilization. For example, paid claims and other administrative databases form a corner-stone of the analysis.

The results obtained from both kinds of analyses overlap too. Feedback or rules that affect the utilization data for a provider are also likely to affect the quality of care that the provider is delivering. For example, a program which reduces the utilization of C-sections by a physician would also impact our assessment of the quality of care that he or she is providing.

When providers are compared to their peers (with appropriate adjustments made for case-mix, urban versus rural access and other factors), we can develop meaningful provider profiles. These profiles can be analyzed and can provide us with screening tools through which we can

focus on certain providers whose practice patterns significantly differ from the norms. These identified providers, in turn, would warrant further review by analytical and clinical staff. This information can also be shared with providers as an educational/informational tool.

Examples of the utilization trends and delivery patterns that we might examine include:

- Inpatient versus outpatient treatment utilization rates
- Average length of stay and changes over time
- Average charges per patient
- C-section and hysterectomy rates
- Vaginal Birth After Cesarean Section Rate (VBAC) rates

We are currently collaborating with several software vendors to create tools that would suit our unique business needs. One of the systems which we are currently putting in place analyzes hospital utilization rates by comparing claims data to national and regional norms.

Another dimension of the examination of utilization trends is that it can be used to examine the effectiveness of various benefit designs. For example, how do certain deductible/copay/coinsurance combinations impact the utilization of various types of services.

These measures are tied in to our measurement of the quality of care. This is addressed more fully in Area II.

Question 12 Case Management to Ensure Appropriate Utilization of Health Care Resources in Treatment and Management of Catastrophic, Chronic and Complex Diseases

JALIC provides case management services to our insureds who suffer a catastrophic illness/injury, and also to our insureds who have a chronic illness and/or complex disease and need our assistance.

JALIC case managers help coordinate the efforts of doctors, nurses, hospitals, home care agencies, etc., all under the direction of the patient's treating physician. At times, alternative treatment measures are utilized if the treating physician desires. JALIC case management is an ongoing process of assessment/evaluation, with each patient being considered on an individual basis. This gives the patient the opportunity to excel to his or her greatest potential.

JALIC case managers realize and respect the fact that the physician is the person in charge and responsible for his or her patient's care. Any concerns the physician and/or insured might have would be reviewed by our Regional Medical Director, Medical Review Committee, and if needed, an outside independent physician specialist peer review. At times we retain an experienced outside independent nurse specialist case manager for an on-site review and assistance in managing the case.

Question 13 Pre-admission and Admission Review to Determine Appropriateness of Admissions

JALIC primarily uses industry standards in the selection of procedures and/or services for pre-admission and admission review.

Patient/provider appeals are reviewed by our Regional Medical Director, Medical Review Committee, and if needed, an outside independent physician specialist consultant peer review.

Question 14 Concurrent Review and/or On-site Review to Determine the Appropriateness of Continued Stay

JALIC UR and/or case managers do concurrent reviews. At times, we retain an experienced outside independent nurse specialist case manager for an on-site review.

If questions or concerns arise, the case is reviewed by our Regional Medical Director, Medical Review Committee, and if needed, an outside independent physician specialist consultant peer review.

Question 15 Discharge Planning to Determine the Appropriateness of Discharge

JALIC UR and/or case managers do discharge planning. At times, we retain an experienced outside independent nurse specialist case manager for an on-site review.

If questions or concerns arise, the case is reviewed by our Regional Medical Director, Medical Review Committee, and if needed, an outside independent physician specialist consultant peer review.

Question 16 Outpatient Utilization Review to Determine the Appropriateness of Treatment and/or Procedure in Outpatient Settings

JALIC primarily uses industry standards in the selection of out-patient procedures and/or services to be reviewed.

Patient/provider appeals are reviewed by our Regional Medical Director, Medical Review Committee, and if needed, an outside independent physician specialist consultant peer review.

Question 17 Pre- and Post-Payment Claims Review

Claims received are systematically matched with pre-certifications. Any discrepancies are resolved with the provider and/or insured.

Question 18 Internal Retrospective Review

JALIC has an internal retrospective review audit program in place.

Question 19 Drug Utilization Review

John Alden currently provides retail pharmacy benefits through a network of pharmacies. The program includes prospective review, using on-line, real time utilization information. In this phase of review, the pharmacist verifies the accuracy and appropriateness of the prescribed medication and assesses the potential of any contra-indications with other drugs currently being prescribed for the patient.

JALIC case managers are involved in Drug UR. JALIC has four contracted pharmacy consultants available to assist us. Two of our pharmacy consultants are doctors of pharmacy. There is close interaction with the treating physician. We educate and encourage our insureds to become involved in their own drug treatment regime, thus complying with what their physician has prescribed.

Patient/provider appeals are reviewed by a doctor of pharmacy consultant, Regional Medical Director, Medical Review Committee, and if needed, an outside independent physician specialist consultant peer review.

John Alden is in the process of adding additional components to our pharmacy program. These components include the use of a voluntary formulary, mail order pharmacy, patient education and retrospective review. Retrospective Review will include the utilization patterns of patients as well as the prescribing patterns of physicians. It will address: generic substitution versus dispense as written (DAW); formulary versus non-formulary; and psychopharmacology dispensing patterns. The review will include *limited, appropriate* intervention with physicians for practice patterns significantly different from the norms.

Question 21 Other Innovative Strategies in Utilization Management

JALIC case managers are proactively involved with the patient and providers of care, in addressing the individual needs of the patient through use of available community resources when possible.

Area Four: Alternative Mechanisms for Payment to Providers (Questions 22 Through 27)

Introduction and Priority Levels

The priorities for the activities included in the questions vary. Priority levels are:

Questions 22 to 25

Risk Sharing	Nationwide-2	Montana-4
Other Activities	Nationwide-1	Montana-1

Questions 26 and 27 are related to quality measurement & risk-sharing, and have the following priority levels:

Nationwide-2 Montana-4

Question 22 Hospital Payment Mechanisms

- Hospital negotiations to reduce overall billed charges
- Centers of Excellence. A network of transplant facilities are made available to all covered lives that require a transplant - regardless of benefit plan design.
- Hospital charges that exceed \$15,000 are triggered by the claims system for review and referral for audit of undocumented charges.

Question 23 Professional Payment Mechanisms

Utilization of several software programs that review professional charges:

- Reviews charges to determine if within prevailing rate
- Reviews multiple surgery charges for "unbundled" procedures. This software package also reviews lab charges for medical necessity and screens for cosmetic or elective procedures.
- Reviews therapy charges to determine if within prevailing rate

Question 24 Outpatient Hospital Services Payment Mechanisms

- Utilization of software to determine if charges are reasonable, based on type of surgery performed.
- The group benefit plans offered by JALIC include a clause that reduces the benefit percentage payable for non-emergency use of a hospital emergency room.

Question 25 Payment Mechanisms May Encourage Bulk Purchasing Through Competitive Arrangements for Durable Medical Equipment, Medical Supplies, Prescription Drugs, and Other Services

JALIC's Managed Care Department contracts with national and state ancillary providers for services, such as durable medical equipment, medical supplies, etc. JALIC case managers are in a unique position of having the opportunity to let the patient and physician know about JALIC's network of contracted providers. Case managers can have an enormous influence in the patient's awareness and access to JALIC provider networks and other alternative resources.

Question 26 Payment Mechanisms may Encourage the Quality Improvement Capacities of Providers

Question 27 Other Innovative Strategies in Payment Mechanisms that Address Reductions in Cost and Administrative Burden, and Quality Improvement of Health Care

Response to Questions 26 and 27

JALIC is developing reimbursement models which link provider reimbursement to quantifiable measures of performance or improvement in performance.

- These incentives involve structuring payment mechanisms to establish a base amount of reimbursement with additional payment for demonstrated superior performance.
- Performance will be measured through tools such as those described in the section on provider assessment. These include evaluation of cost-effectiveness, quality of care, access, and patient satisfaction.
- Key components of the reimbursement model to be determined include:
 - the base amount of reimbursement relative to the amount linked to performance.
 - the measures used to determine the amount of additional performance-based reimbursement.
 - the linkage between performance and additional reimbursement.
- Reimbursement model parameters will vary according to the managed care setting in which they are used (e.g., PPO, EPO, HMO, etc.).
- Performance-based reimbursement mechanisms should rely on easily obtainable data, be introduced to providers in phases, and be easily explained.
- JALIC can assist parties in obtaining agreement regarding the implementation of performance-based reimbursement mechanisms.

Area Five: Third Party Liability/Coordination of Benefits (Questions 28 Through 32)

Priority Levels

The priority level for all of Area Five is as follows:

Questions 28 to 32	Nationwide--1	Montana--1
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Question 28 Data Matches to Other Organizations and Insurers that Capture Relevant Data

We use independent companies to match our insured's social security number to other organizations relevant to Workers Compensation and other third party payers.

Question 29 Cost Avoidance Processing Through Review of External Databases

All auto accidents are carefully reviewed for fraud, COB and Right of Recovery. We use several independent investigator's for their database to identify other payers liabilities.

Question 30 Calculation of Average Savings to Cost Ratios to Determine Cost-effectiveness of Third Party Liability/Coordination of Benefits Activities

Reports are generated on a monthly basis which show total dollars "saved" through COB activities, as well as the corresponding percentage of total claims dollars paid out. Reports are also generated showing the dollars recovered under the "Right of Recovery" provisions in the benefit plans.

Question 31 Coordination of Benefits

Our computer system has a special screen to keep all COB information current. We keep a 3 to 5 day turn-around time on our claim handling and correspondence.

Question 32 Other Innovative Strategies in Other Party Liability

We follow the standard guidelines set forth by NAIC regarding COB for the primary and secondary roles for insurance carriers.

Area Six: Administrative Methods (Questions 33 Through 38)

Priority Levels

The priority level for all of area six is as follows:

Questions 33 to 38

Nationwide-1

Montana-1

Question 33 Acceptance of Standardized Claims Format

All standardized claims formats are acceptable for claims submission. JALIC does not require the completion of any claims forms by our insureds, providing all pertinent information is included on provider billing statement.

Question 34 Collection of Information to Support a Unified Database

- JALIC is currently updating our insured member records to include valid social security numbers. A mailing was sent to all Montana employers in late January to verify our current social security number information.
- Our provider file database is accessed by the provider's tax identification number.
- The claims paying system utilized by JALIC was developed in-house and provides multiple edits and validation processes. A few examples include: comparing diagnosis to service performed, matching provider specialty to procedure performed, and place of service to service performed.

Question 35 Acceptance of Common Coding Schemes

Our claims paying system requires the usage of the following coding schemes: CPT, HCFA, ICD-9-CM, DSM III, ADA dental codes and Revenue Center Codes.

Question 36 Move to Adopt Workgroup on Electronic Data Interface, or other National Efforts Toward Electronic Standardized Formats

As of March 1994 we will be receiving claims electronically. Eligibility, enrollment and payment will be Phase 2 of this project, which is tentatively scheduled for early 1995.

Question 37 Procedures to Conduct Internal Performance Monitoring

Continuous internal performance monitoring takes place in all areas of administration.

- Costs are reported and reviewed monthly by management personnel. Any increase in expenses is investigated and addressed, if appropriate.
- The Customer Service Department is available from 8:00 - 6:00, Monday through Thursday, and 8:00 - 4:30 on Fridays, to address all customer needs and concerns. Via a toll-free 800 number, patients and providers can obtain claims information as well as premium and underwriting status.
- Claims performance standards have been set and met on a continuous basis. Daily, weekly and monthly reports are generated to track mail received, claims backlog, turn around time and pended claims. Claims audits are performed on each claims examiner monthly, with accuracy/quality standards enforced.

Question 38 Other Innovative Strategies in Administrative Management

JALIC fully endorses the philosophies and practices of Continuous Quality Improvement. Ongoing education and training for our employees ensures consistency in procedures, and presents opportunities for employees to form quality improvement teams to develop more efficient work processes.

Also, our computer systems are constantly being improved with time-saving, cost-reducing enhancements that also ensure quality and consistency in claims processing.

Area Seven: Anti-Fraud (Questions 39 Through 40)

Priority Levels

The priority level for all of area seven is as follows:

Questions 39 and 40

Nationwide-1

Montana-1

Question 39 Fraud and Abuse Controls

Our Fraud Unit provides ongoing training of the new types of fraud and abuse. Our computer system has the capability to "red flag" providers based on their provider tax I.D. These "red flagged" providers are handled by our Fraud Unit and are updated as new providers are detected.

Question 40 Other Innovative Strategies that Address the Involvement of Providers and Patients in Control of Fraud and Abuse

Our computer system includes "Claims Edit" which suspends claims for multiple services, routine lab, unbundled procedures and other areas where abusive claims practices can be found.

JOHN DEERE INSURANCE COMPANY

3400 80TH STREET, MOLINE, ILLINOIS 61265-5886
TOLL FREE 800/447-0633 CLAIMS 800/635-3377

3 March 1994

Mr. Mike Craig
Montana Health Care Authority
28 N. Last Chance Gulch
P. O. Box 200901
Helena, MT 59620-0901

Re: Dorothy Bradley's letter on Cost Management Plans dated January 7, 1994 and received February 23, 1994

Dear Mr. Craig:

Thank you for the information you provided about the cost management memorandum. I am sorry to hear that you had such a mailing problem.

As I discussed with you by the phone on March 1, John Deere Insurance Company is an indemnity insurer. John Deere Insurance Company writes only one health policy, a group health policy issued to the John Deere Dealer Group Insurance Trust. JDI has not adopted many of the items your study suggests, which are more typically found in managed care plans. However, we have implemented certain important cost-containment measures.

John Deere Insurance Company's principal method of cost management is contracting with a utilization review entity. This organization, IntraCorp, is nationally known. IntraCorp provides hospital percertification, medical case management, and utilization review.

The policyholder has investigated contracting with PPOs, but has not yet done so. We contract with a mail order prescription drug provider, Value Rx, to help reduce prescription cost for insureds. Regarding coordination of benefits, John Deere Insurance actively pursues subrogation and coordination of benefits. Our claim process requires that the claimant identify any other insurance.

Regarding administrative methods, John Deere Insurance changed its claims processor on January 1, 1994. The new claim processor provides a much lower cost per claim and guarantees 2-day turnaround on claims. The TPA accepts UB 92s and HCFA 1500 forms.



JOHN DEERE
INSURANCE

AFFILIATED COMPANIES

JOHN DEERE INSURANCE COMPANIES OF CANADA
JOHN DEERE LIFE INSURANCE COMPANY
JOHN DEERE TRANSPORTATION SERVICES, INC
ROCK RIVER INSURANCE COMPANY
SIERRA GENERAL LIFE INSURANCE COMPANY
TAHOE INSURANCE COMPANY

JOHN DEERE INSURANCE COMPANY

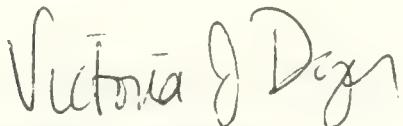
3 March 1994
Mr. Mike Craig
Page 2

We do pay for certain services provided by allied health professionals. Our policyholder has coverage for nurse practitioners and midwives.

Because of the short amount of time due to the delay in the mailing, this is a very abbreviated response; however, you indicated that this would be sufficient. If this is not the case, please feel free to call.

Enclosed is the health insured data sheet.

Very truly yours,



VICTORIA J. DYER
Assistant Secretary

VJD:sd

Enclosure

c: Dan Stansberry
Susan Poe
Mike Ficken

Life & Health of America

2200 Walnut Street • Philadelphia, PA 19103 • (215) 567-1246

February 9, 1994

ROSS D. MILLER
General Counsel

Ms. Dorothy Bradley
Montana Healthcare Authority
28 North Last Chance Gulch
P.O. Box 200901
Helena, MT 59620-0901

Re: Cost Management Plan

Dear Ms. Bradley:

I am in receipt of your memorandum dated January 7, 1994. As you are aware, that memorandum requests the filing of an insurer cost management plan on or before March 1, 1994. Below, I shall set forth our company's responses to the questions set forth on pages 7 through 16 of the attached set of standards and guidelines. Also enclosed please find a completed health insurer data sheet as required.

1. None
2. 10% discount for non-smokers
3. Our Home Health Care and Long Term Care policies provide requirements and benefits which promote cost effective services. Specifically, both plans require that care be rendered in the home or in a long term care facility in lieu of confinement in a hospital. Additionally, the company shall only pay for the level of care certified as medically necessary by the insured's physician.
4. The company has enlisted the resources of Medical Resources Ltd. and Community Health Services Inc. These outside firms have contracted with various healthcare providers to provide discounted rates to the company's insureds.
5. See #4 above.
6. None
7. Both Medical Resources Ltd. and Community Health Services have utilization review provisions in their contracts with the various health care providers.
8. See #7 above.
9. None
10. None
11. None
12. The company has contracted with various paramedic

organizations to provide in home evaluations of those insureds who are currently on claim with the company. Through these evaluations the company can measure what level of care is actually needed for each insured. It also measures whether an insured has achieved recovery sufficient enough to reduce the time necessary for a home health practitioner in the home.

13. None
14. See #12 above.
15. None
16. None
17. The company has on occasion discovered overpayments of claims. In such instances the company makes demand for reimbursement by the health care provider. The company has always experienced success in recovering overpayments of claims.
18. The company utilizes the services of an outside medical director to review all claim files. The doctor reviews both past medical records and past medical records to ascertain the need for Home Health Care or Long Term Care.
19. None
20. None
21. None
22. Community Health Services Inc. has preferred rates for several Home Health Care providers. It is those providers to whom Community Health Services refers insureds who call for a Home health Care reference. Accordingly, the most competitively priced Home Health Care providers receive the most referrals.
23. None
24. None
25. None
26. None
27. None
28. None
29. None
30. None
31. None
32. None
33. While the company does accept claim form HCFA1500 and HCFA1450, the company does require completion of its own claim form prior to payment of any claim.
34. None
35. The company does accept the HCFA common procedure coding system and the ICD-9-CM system.
36. None
37. The company is currently engaged on a continuing basis, in monitoring the quality control of the Claims Department. This system reviews all personnel in the Claims Department and all levels of activities within the scope of their employment. The company measures the timeliness or response to insureds, the quality of service rendered to the insureds, the accuracy of the claim payments made to the insureds, the relationships created between the examiners and the insureds and an ongoing

- review of administrative costs.
38. None
39. The manager of our Claims Department puts any suspected occurrences of fraud to the office of the General Counsel. That office then commences an investigation utilizing such services as Equifax and private investigators to ascertain the facts of the case. In appropriate instances the company forwards information on suspected fraudulent activities to the appropriate insurance department and law enforcement officials.
40. None

I hope that I have fully responded to your request for information. Please feel free to contact me should you have any questions or require any additional information.

Very truly yours,



Ross D. Miller, Esq.
General Counsel

RDM/sd

Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690



Thomas B. Considine
Government Relations Counsel

Ms. Dorothy Bradley
Montana Health Care Authority
PO Box 200901
Helena, MT 059620-0901

Dear Ms. Bradley:

I am enclosing MetLife's Cost Management Plan ("CMP"), which you requested from us in a memorandum dated January 7, 1994. I have not included a Health Insurer Data Sheet with the CMP because we have not been able to identify any policies issued to customers in Montana that are covered by the data sheet. We are continuing to investigate whether we have customers in other states whose policies cover Montana residents. If we determine this to be the case, we will be happy to provide you with that information.

Please do not hesitate to contact me directly if I may be of any additional assistance.

Very truly yours,

A handwritten signature in black ink that reads "Tom Considine".

Thomas B. Considine
Government Relations Counsel
Government & Industry Relations

March 24, 1994

Enclosure

MetLife's Cost Management Plan

Prepared for the Montana Health Care Authority

February, 1994

INTEGRATED SYSTEMS FOR HEALTH CARE DELIVERY

At MetLife, we believe that building a relationship with our customers is the best way to learn about their needs. This relationship enables us to determine what strategy would best suit a particular company. Because customer needs and goals can differ, MetLife's Managed Care Strategy has the flexibility and resources to keep benefit plans in sync with a company's goals. To address the varying concerns of our customers, MetLife offers an array of managed care programs:

MET-ELECT PREFERRED PROVIDER PROGRAM

POINT OF SERVICE PROGRAM

MULTI-OPTION PROGRAM

HMO PLAN

Please note that due to our limited customer base in Montana, none of these network-based programs are currently offered in Montana.

Each of these programs is described below:

METLIFE'S MET-ELECT PREFERRED PROVIDER PROGRAM

Met-Elect is MetLife's Preferred Provider Program. Because Met-Elect is a PPO, it may be the right choice for employers who are just testing the managed care waters, and are not completely ready for major plan revisions.

HIGHLIGHTS:

- o Met-Elect provides the greatest degree of freedom of choice among the managed care plans.
- o Implementation is easy because major plan revisions may not be necessary.
- o The individual makes the decision whether or not to use a network preferred provider each time he/she seeks health care services.
- o Higher benefits are paid when a network preferred provider is used. This encourages use of network providers.
- o Employees are responsible for initiating the "Hospital Preadmission Certification," and pre-treatment "Procedure Evaluation Program" processes when necessary.

PRIMARY CARE PHYSICIAN-BASED PROGRAMS

For those employers who wish to have a greater degree of managed care involvement, MetLife offers the three programs that follow - MetLife's^R Point of Service and Multi-Option programs, and the MetLife^R HMO plan. These programs utilize the concept of a Primary Care Physician (PCP).

- o When used in conjunction with our medical management programs, we strongly believe that a PCP-based program which includes coordination of care, can be the most effective mechanism for managing care.
- o The PCP approach designates one physician as the "manager" of an employee's care. In essence, this means that the physician would either provide care or refer patients to network specialists or hospitals.
- o Employees select their PCP from a network directory.

METLIFE'S^R POINT OF SERVICE PROGRAM

Our Point of Service (POS) program offers the greatest degree of freedom of choice among the PCP-based programs. As is true with Met-Elect (our PPO), the decision to use, or not to use, the network providers is made each time an employee seeks medical care. However, unlike Met-Elect, all in-network care must be provided by, or arranged through, the PCP.

HIGHLIGHTS:

- o The decision to use, or not to use, the network providers is made at the point of service.
- o Employees and their dependents choose their own PCP to manage their care.
- o Higher benefits are paid for health care received in-network. Incentives can vary to conform to an employer's financial and/or benefit plan objectives.
- o The PCP will refer patients to other network specialists and/or hospitals.
- o In-network benefits are similar to those offered in an HMO plan (i.e., preventative care, etc.).
- o Individuals going in-network are responsible for a flat dollar co-payment for each office visit, while those using an out-of-network provider must usually satisfy a deductible and then pay coinsurance for an office visit.

- o When employees use the network providers, utilization review and surgical necessity review processes are initiated by the provider (unlike the PPO program which requires employee involvement).
- o Employees who use a network provider generally do not have to submit any claim forms for in-network care (individuals who go out-of-network must).

METLIFE[®] MULTI-OPTION PROGRAM

Multi-Option is another PCP-based program. This combines the MetLife[®] HMO Plan (described below), provided through our affiliated MetLife HealthCare Network HMOs, with a traditional indemnity plan. Employees can choose their level of benefits at the time of enrollment, selecting between indemnity or HMO-type coverage. Employees who wish to change their coverage after the enrollment period may do so at specified intervals (i.e., three months).

Highlights for Multi-Option can be found below in the MetLife HMO Plan section.

METLIFE[®] HMO PLAN

For those employers looking to most effectively control health care costs and consolidate the number of HMOs offered to their employees, the MetLife HMO Plan, offered by our affiliated MetLife Network HealthCare Companies, can be utilized on a stand-alone basis.

HIGHLIGHTS:

- o For services to be covered, all employees must have care provided by, or arranged through, the HMO network of participating providers.
- o The MetLife HMO Plan may include co-payments, deductibles, coinsurance, and/or out-of-pocket expense limits, although minimal co-pays are the most frequently used cost-sharing mechanism.
- o Employees rarely need claim forms, so administration is simplified.

METLIFE'S PROVIDER NETWORKS

Drawing from our massive collection of health care claim data, MetLife identifies high value, cost-effective health care providers in a given geographical area. Then, if they meet a variety of criteria, they are considered for acceptance into a MetLife Network.

The number of hospitals, physicians, and ancillary providers is constantly being reviewed and evaluated and we have a network in virtually every major urban area.

As of February 1, 1993, MetLife has:

- o 78 Provider Networks Nationwide
- o Networks in 33 states, plus Washington, D.C.
- o 990+ Hospitals
- o 80,000+ Physicians and Ancillary Providers

HOSPITAL SELECTION CRITERIA

Under our current procedures, hospitals must prove accreditation and specified levels of liability insurance, offer a range of services, and have a geographical location in keeping with the networks' accessibility. Currently, our procedures for selecting hospitals generally include the following:

- o We verify accreditation by the Joint Commission of Accreditation of Hospitals through written documentation.
- o We obtain evidence of insurance coverage for both general and professional liability insurance.
- o We determine the community's perception of a hospital's quality through consumer research.
- o We choose hospitals with a range of services and geographic locations which will enhance the total network service area.
- o We use case mix Diagnosis Related Groups (DRGs) analysis to identify hospitals which will be considered for our networks.

Hospitals are typically reimbursed on per diems, DRGs, or other discount arrangements.

PHYSICIAN SELECTION CRITERIA

Since the majority of a hospital's expenses are ordered by physicians, we believe that an analysis of that hospital's efficiency also reflects the efficiency of its staff. Therefore, under our current procedures, once a hospital is accepted into a MetLife Network, selected

physicians with admitting privileges are also invited to join - subject to a thorough review of their professional and academic credentials.

The following are a few sample requirements from the credentialing process that physicians must generally pass before they are invited to join a MetLife Network:

- o Physicians must have an active state license and a controlled substance prescription license.
- o They must have unrestricted privileges at a MetLife Network hospital.
- o They must provide evidence of active unrestricted malpractice coverage. They must provide full disclosure of any past or pending malpractice cases.
- o They must provide full disclosure of prior disciplinary action and any sanctions invoked by Medicare, Medicaid, DEA, State Board of Examiners, hospitals, or other third party payor programs.
- o They must be able to provide 24-hour coverage and be available during reasonable office hours.

Physicians in our networks are typically reimbursed according to a fee schedule. In some of our HMOs, providers are capitated.

In addition, we use a sophisticated, computer-based Network Adequacy Model which uses geo-coding and provider/member ratios to monitor network adequacy and contracting objectives

METLIFE'S MEDICAL MANAGEMENT PROGRAMS

Careful provider selection and negotiated fee schedules are only part of what MetLife has to offer in our managed care strategy. Enhancing the effectiveness and delivery of all our managed care programs are the MetLife Medical Management Programs:

HOSPITAL UTILIZATION REVIEW (MET-REVIEW^R)

AMBULATORY UTILIZATION REVIEW^{SM*}

CASE MANAGEMENT

CENTERS OF QUALITYSM

HEALTHY PREGNANCYSM PROGRAM

*Networks only - not available in Montana

These programs have been developed and are administered by our Medical Directors (medical doctors) and Nurse Managers at Medical Management Centers nationwide. Together with MetLife's comprehensive provider networks, they form today's most effective mechanism for delivering cost-effective, quality managed care programs.

MET-REVIEW^R

Met-Review is our comprehensive hospital utilization review (UR) program. It is designed to help eliminate unnecessary hospital admissions and inappropriate lengths of stay. This program maximizes the use of cost-effective alternative treatment settings when appropriate.

The primary features of Met-Review are:

- o **Preadmission Review** of non-emergency admissions and admission review of emergency admissions to help ensure appropriate care is provided in the most appropriate setting.
- o **Concurrent Monitoring** of inpatient care which is conducted throughout a patient's hospital stay. The goals of concurrent monitoring are to evaluate the continuing need for hospital-level care, identify any inappropriate delay of necessary hospital care, initiate discharge planning as soon as appropriate after admission, identify opportunities to initiate case management intervention, and generate data to identify current patient care practices and associated activities.

- o The Health Care Help Line is a toll-free telephone information service built into our UR program. The Health Care Help Line was created because MetLife believes in the importance of educating employees to help them become knowledgeable, cost-conscious users of the medical care system.
- o The Procedure Evaluation Program takes a practical and cost-efficient approach to controlling unnecessary surgery and outpatient and ambulatory testing. All proposed surgical procedures and ambulatory tests are subject to review. However, with this approach, the requirement for a second surgical opinion is waived by the MetLife Nurse Reviewer when an individual's symptoms or medical history meet certain generally accepted criteria. When a second opinion is required, the patient will be provided with the names of board certified doctors in his/her area.

AMBULATORY UTILIZATION REVIEWSM

As more and more services are shifted from the hospital to alternative settings, the need to control the benefit costs of outpatient treatment increases. MetLife has developed a comprehensive Ambulatory Utilization Review (AUR) program which provides for the network component of our products:

- o Retrospective analysis of physician visits, diagnostic x-rays, emergency room visits, lab tests, and other ambulatory procedures by using nationally accepted standards as a statistical database.
- o Identification, through analysis, of aberrant treatment patterns for a given diagnosis.
- o Automatic AUR activation - since the statistical database is loaded onto our electronic claims systems, AUR takes place automatically each time an ambulatory claim is processed for payment.

CASE MANAGEMENT

It is a fact that a small number of cases can often represent a very large portion of claim dollars. Case management gives specific attention to those cases that are likely to require large expenditures of health care resources.

The objective of case management is to help employees and their families deal with catastrophic medical situations in a way that is better for everyone involved. This is accomplished through:

- o Increased availability of benefits for less costly alternatives to hospitalization, when medically appropriate.

- o Rapid mobilization and implementation of care - our program is structured to provide early identification and intervention as well as alternatives that can reduce hospital, physician, and ancillary costs.
- o Alternative Care - in some cases utilization of alternative care facilities can reduce claim expenditures and provide care more appropriate for an individual's condition.
- o Rehabilitation - patients who might benefit from rehabilitation services are identified and an appropriate alternative treatment plan will be suggested.

CENTERS OF QUALITYSM

This program is an extension of case management and is intended to have high cost transplant cases such as heart, liver, kidney, and bone marrow transplants treated at selected institutions. Patients are identified either through case management or UR, or can self-refer into the program. Our medical management team reviews each case, and where appropriate, may suggest treatment at a Centers of Quality hospital.

Care at a Centers of Quality hospital offers many attractive features including:

- o A higher level of benefits than would otherwise be provided. For example, deductibles, coinsurance, or co-pays could be waived, and patient travel expenses are generally eligible for reimbursement.
- o Care provided by institutions that have been identified as having recognized expertise in performing certain complex surgical procedures.
- o Negotiated discounts with most of the institutions, plus additional savings resulting from better patient outcomes (i.e., fewer infections and complications).

CENTERS OF QUALITYSM FACILITIES

MetLife's current Centers of Quality facilities include:

Cardiac Transplants:

Arizona - University of Arizona

California - Stanford University Medical Center

New York - Columbia Presbyterian Medical Center

Ohio - Cleveland Clinic

Liver Transplants:

California - University of California, Los Angeles

Pennsylvania - University of Pittsburgh Presbyterian University Hospital

Kidney Transplants:

Arizona - Good Samaritan Regional Medical Center

California - University of California, Los Angeles

Colorado - St. Luke's/Presbyterian Medical Center

Illinois - Rush/Presbyterian/St. Luke's Medical Center

New York - New York Hospital/Cornell Medical Center/Rogosin Kidney Center

Ohio - Christ Hospital and the Cleveland Clinic

Pennsylvania - University of Pittsburgh Presbyterian Hospital

Texas - Methodist Hospital, Baylor University

Bone Marrow Transplants:

Massachusetts - Children's Hospital of Boston and the Dana Farber Cancer Institute

Minnesota - University of Minnesota

Texas - University of Texas/M.D. Anderson Cancer Center

THE HEALTHY PREGNANCYSM PROGRAM

This is a voluntary educational program which identifies employees at risk for premature labor and delivery. This approach combines employee education with case management and strives to avert or delay premature delivery.

In the healthy pregnancy program:

- o High-risk patients are identified through UR or self-referral.
- o Each pregnant woman receives comprehensive information to answer frequently asked questions about pregnancy and to explain current diagnostic techniques.
- o If a patient is assigned to a high-risk group, her doctor is contacted, and the case is reviewed for possible case management services.
- o The goal of the program is to have high-risk pregnancy employees provided with more intensive prenatal care to minimize the risk of having premature births - which can cost between \$50,000 and \$100,000 more to care for, on the average, than babies born at term.

OUTCOMES MANAGEMENT

In 1991, a consortium of major U.S. employers and managed care organizations initiated a joint project to evaluate outcomes of health care among benefit plan members. Twenty-four companies have committed themselves to the planning phase of a feasibility study and demonstration project. MetLife and two of our prominent managed care customers, Procter & Gamble and the Promus Companies, are participating in this effort.

The overall objectives of this collective effort are:

- To demonstrate the commitment of managed care purchasers and the managed care industry to the rigorous evaluation of benefit programs in terms of health outcomes;
- To assess and report on the economic, political, and administrative issues in implementing outcome-based evaluations; and
- To contribute to the general body of information linking the process and outcomes of medical care.

The outcomes consortium emerged from discussions between several members of the Managed Health Care Association, an employer organization committed to quality improvement in managed care, and Paul Ellwood, M.D., policy analyst and president of InterStudy, a major health care think tank. InterStudy is serving as the project coordinator with medical researchers from several major universities providing ongoing consultation.

Consortium members are committed to exploring the feasibility and usefulness of "outcomes management" in improving the quality and cost-effectiveness of medical care. Key components in outcomes management include:

- The establishment of a common, patient-understood "language" of health outcomes, including mutually agreed-upon measurement and data analysis techniques.
- Centralized data pooling and analysis, widely accessible to decision maker, relating medical interventions to health outcomes.
- Accurate, timely, and understandable feedback to payers, providers, and patients.

Contributing to the emerging technology of outcomes management, InterStudy has developed the "Outcomes Management System" (OMS). Created by a national team of medical authorities commissioned by InterStudy, the OMS consists of several general and disorder-specific measures of functional status and well-being. The OMS is designed for

routine measurement of health outcomes by means of questionnaires completed directly by patients and providers.

During the project planning phase, the outcomes consortium will focus on designing methods to measure outcomes for selected conditions, including angina, low back pain, and asthma. In subsequent stages of the project, OMS and related data will be collected in selected cities throughout the United States. Data collected in the demonstration project will be maintained with strict confidentiality regarding employers, managed care companies, providers, and patients. Use of data to compare the performance of participating providers or managed care companies is not anticipated during the feasibility phase.

In the future, we hope to be able to develop a mechanism to link reimbursement to outcomes.

PHYSICIAN FEEDBACK REPORTS

In 1991, we introduced PCP Feedback Reports as a new quality assurance tool for monitoring and helping to improve Primary Care Physician (PCP) practice patterns. The reports compare PCP performance to local network and specialty norms and present the comparisons using easy-to-interpret graphics. They cover: office visits, referrals, procedures, tests, x-rays, emergency room visits and hospitalizations.

The PCP Feedback Report package helps zero in on key area by using a 5-step progressive magnification process. This approach supports the process of Continuous Quality Improvement (CQI) by not only identifying "aberrant" PCP behavior, but also, and more importantly, by uncovering examples of PCPs' "best practices." Since the major purpose of the report package is to feedback information to PCPs in order to help them improve their practice patterns, such examples are invaluable.

HEALTH PROMOTION AND HEALTH EDUCATION

MetLife's Medical Department's Health Safety Division develops and disseminate a wide variety of health education materials including pamphlets and booklets. It will also develop health risk assessment and wellness programs for customers.

Our Group Department's managed care operation also provides a number of programs for our HMO and POS members including:

- **MetLife HMO's Child Health Initiative™ Program** provides child care information to parents of children from birth through five years. The purpose is to assist and support parents in promoting the optimal health and development of their children. Shortly before a child's birthday each year, parents receive one of six age-specific books containing child care information on nutrition, safety, development, and parenting. Particular emphasis is given to safety and to timely immunization. When an immunization has not been recorded at the appropriate age, a reminder will be sent to the child's parents.
- **MetLife's HMO's Women's Health Initiative™ Program** includes a book providing information on such women's health care concerns as birth control, breast cancer, and menopause, as well as healthy nutrition, exercise, and self-image.

MetLife HMO will provide monitoring and reminders in connection with regular gynecological checkups, including mammograms.

- **MetLife HMO's Men's Health Initiative™ Program** provides a book which recognizes many of today's concerns for men, including healthy nutrition and exercise, prostate and testicular cancer, and balding, as well as sexually transmitted diseases. MetLife HMO will provide monitoring and reminders about recommending checkups.
- **Health Letter**, a member newsletter produced in conjunction with a leading health care publisher, offers practical and up-to-date information on healthy lifestyles.

As part of our never-ending quest to bring extra enhancements to MetLife HMO membership, we also offer additional programs such as:

- **Fitness Walking**, a self-monitoring walking program, including well-researched recommendations and charts to keep track of progress made.
- **Healthy Nutrition**, which provides delicious and easy-to-follow recipes, as well as tips by the author of a well-known book on low-fat diets.

- **Smoke Cessation**, a special version of the American Lung Association's successful 20-day program, can offer meaningful support to anyone who has made this very important decision for better health.
- **Weight Reduction**, information outlining a sensible approach to calorie counting.
- **Other Programs**

MetLife HMO offers its members a variety of value-added programs and educational materials that focus on the pursuit of healthier lifestyles.

These programs for MetLife HMO members may not be available in all locations.

Quality Improvement and Assessment

Objective: Quality assurance activities promote cost management because high quality care has been found to be the most cost-effective care. Insurers should promote quality care through the identification of providers who can demonstrate a quality assurance process and through the use of outcomes data to monitor provider performance. MetLife has adopted the standards of the National Committee on Quality Assurance (NCQA) as the operational guidelines for implementing continuous quality improvement (CQI) processes.

Strategies:

1. Contracting with providers with quality assurance processes in their treatment settings that reflect certain critical components.

a. Credentialing of physicians containing data elements which reflect aspects of clinical competence and performance, including sanction-free licensure, malpractice history, hospital privileges in good standing, specialty board status and appropriate inquiries to the National Practitioner Data Bank.

b. Tracking of voluntary disenrollments, member requests for a change of primary care physician, member grievances related to quality of care or quality of service and member access/satisfaction survey results.

2. Collection of data on efficiency, quality and patient demographics and health status to support valutative functions and outcomes research.

a. Practice guidelines developed by the Rand Corporation have been incorporated into the medical/surgical review criteria in 1993.

b. Ambulatory care guidelines developed by Concurrent Review Technologies were incorporated into the ambulatory review criteria in 1989.

c. We have been working towards introducing diagnosis-specific clinical practice guidelines into the quality improvement process.

d. We also have been working towards conducting outcomes research involving functional outcome.

e. A Primary Care Physician Feedback Report to provide PCPs with information concerning their cost-efficiency relative to their peers was implemented in 1991.

f. Evaluation of the continuity and coordination of care by auditing primary care physicians' charts in order to ascertain their level of performance.

g. Risk management activities including annual survey of the physician's office facility, audits of the organization of the medical record, audits of the clinical content of the physician's medical records, quality management indicators related to member hospital in-patient care and tracking of member grievances related to quality of care issues.

h. Pre-contractual survey of all physicians' offices to evaluate the physical facility and medical record-keeping practices of the physicians.

3. Use of provider profiling results in development of quality improvement and assessment features, such as:

Use of provider profiling to measure:

a. Access - patient access to physician and hospital care is measured as a function of patient satisfaction.

b. Outcomes - provision of preventive health care services to men, women and children is monitored.

c. Treatments - the 1993 Medical Review System will incorporate surgical outcome measures.

d. Diagnoses - the 1993 quality improvement plan specifies small-area analysis and diagnosis-specific outcome evaluation.

e. Satisfaction - we evaluate patient and hospital specific member satisfaction

Use of process measures to determine:

1. Compliance with standards for care of chronic conditions, preventive services screening.

Compliance with written process standards (bench marks are monitored by both claim data base surveys and physician chart audits).

2. Whether the number of tests, procedures or referrals occurred in a given time period.

This is being done presently for preventive health services focusing on breast cancer, cervical cancer, coronary artery disease and childhood immunization. We are developing clinical practice guidelines against which we will monitor the process of care.

Use of outcome measures:

1. We currently assess outcomes of hospital care related to more than 50 quality indicators including anesthesia complications, infectious complications, mortality and surgical complications.
 2. Currently in various stages of development are projects involving evaluating patient functional status and health status.
4. Other innovative strategies in quality improvement and assessments.
- a. We have implemented the surgical appropriateness criteria developed by Value Health Sciences Inc.
 - b. We are participating in the Outcomes Management System (OMS) trials conducted by their Managed Healthcare Association in cooperation with InterStudy.
 - c. We are participating with ECRI and Hayes, Inc. in the area of technology assessment.
 - d. We are exploring a venture with the Center for Knowledge Coupling in the area of expert systems and clinical practice guidelines.

Utilization Management

Provider profiling to determine utilization trends and service delivery patterns. Provider profiling may include:

- o Collection, analysis and interpretation of provider practice data using statistical methods and small areas analysis.**

The MetLife® Ambulatory Utilization Review™ Program, incorporating the Health Payment Review Patterns of Treatment™* developed by Dr. Donald Harrington, provides a method for monitoring the frequency and intensity of ambulatory services (i.e. office visits, laboratory testing). Reports by network and provider are produced and used to monitor physicians participating in the MetLife networks. The local Medical Directors may use the data provided in the reports as a basis for discussion with the participating provider when appropriate.

MetLife has also developed and implemented the Quality Management Indicator™ (QMI) Program which addresses complications arising during the course of inpatient hospitalization. QMI data is being tracked in each Medical Management Center and will be used by the Quality Management Committee to focus our quality improvement efforts.

Nationally, MetLife is in the process of implementing "Primary Care Physician - PCP - Feedback Reports." These reports, based on claims and utilization data, compare individual PCP practice patterns with local network peers within the same specialty. The reports address, among others: office visits, referrals, procedures, tests, x-rays, emergency room visits and hospitalization. These reports are intended to provide participating PCPs with accurate, meaningful and timely information to help them evaluate their own practice patterns in relation to the practices of their peers.

* Patterns of Treatment is a registered trademark of Concurrent Review Technology, Inc., a wholly owned subsidiary of Health Payment Review.

- o Establishment of specific standards for provider performance; providers who meet the profiling performance standards may be exempt from further review, thereby reducing the need for case-by-case review. High and low outliers should be identified for more detailed review.

Presently providers who meet profiling performance standards are not exempted from the requirement to precertify hospital admissions and certain outpatient procedures/treatments. Reducing physician hassle and the administrative expenses that attend it is a medical management goal.

Case Management to ensure appropriate utilization of health care resources in the treatment and management of catastrophic, chronic and complex diseases. Case management may include:

- o **Case management for catastrophic illness and injuries.**

Case Management is a voluntary program. The objectives of CM are to identify benefit options for participants; coordinate the sequence of care by facilitating communication among participants, providers and other involved individuals; increase the participant's awareness of treatment options, particularly those available which offer a special financial incentive; and provide a mechanism for monitoring the participant's progress over the full course of a health problem.

- o **Management of treatment and care of patients with chronic conditions.**

MetLife's voluntary case management program may be appropriate for patient's with chronic conditions. Case Management Program Benefits may be made available if services are identified which are expected to be medically necessary and more cost effective than the services covered under the health benefit plan. As well, case management medical professionals can provide information concerning benefits available under the health benefit plan and alert the physician to the availability of providers that have negotiated fee arrangements with MetLife, such as participants in the national ancillary provider network. Of course, the patient and the physician have responsibility for all decisions about the treatment provided.

- o **Case management for complex diseases and procedures with programs designed for treatment to occur in the most appropriate setting (for example, outpatient departments, home) and with the most appropriate service (for example, home health, nursing home).**

The Case Management Coordinator conducts an extensive clinical assessment to identify the most cost-effective and medically beneficial alternate services. The factors that will be considered include the patient's age, past medical history, severity and duration of condition, prognosis, family structure, availability of specialized rehabilitation, and potential for cost savings. The CM Coordinator suggests only those facilities and programs that are appropriately licensed and accredited based on the type of facility or program.

MetLife and its affiliated HMOs have entered into contracts with a range of national ancillary service providers in the areas of home health care, home infusion therapy, durable medical equipment, perinatal services, laboratory services, acute rehabilitation services, skilled nursing facilities, transitional living centers, and air ambulance. An extensive review process was conducted to select the providers participating in the National Ancillary Provider Network.

The MetLife® Centers of Quality™ Program is a voluntary program through which MetLife has identified hospitals nationwide with recognized expertise in performing certain complex surgical procedures such as heart, liver, kidney and bone marrow transplants.

- o **Assessment of the case management process to determine that patients progress, meet treatment goals, and are not being over- or under-served.**

The CM Coordinator continually gathers information from the attending physician, family members and other medical providers by telephone. On-site assessment may be warranted in certain situations in order to obtain information regarding the patient's medical condition and/or the patient's family or living situation; a facility which may provide alternate services and has not been previously utilized by CM (on-site facility review); and/or at a customer's specific written request. Each active case management case is monitored, reviewed and evaluated on an on-going basis to monitor the patient's progress and to determine the need for continuing CM involvement.

- o **Development of patient/provider appeals process for adverse decisions resulting from the discharge planning process.**

A reconsideration process is available as described in Attachment A.

Preadmission and admission review to determine appropriateness of admissions. Preadmission and admission review may include:

- o **Focused review of the conditions and treatments that are known to have higher rates of variation and inappropriateness.**

Local Medical Directors may identify certain diagnoses and procedures which are targeted for more intense scrutiny in both ambulatory and inpatient review. As well, local Medical Management Centers utilize focused studies and clinical audits to focus on items related to local problems identified as part of the quality assurance process.

- o **Review of elective admissions prior to hospitalization, including elective C-Sections.**

Met-Review® (Hospital Utilization Review) is a comprehensive hospital utilization review program. It reviews the medical necessity of hospital admissions and lengths of stay using nationally accepted medical standards. Met-Review is designed to help avoid unnecessary hospitalizations and stays that are longer than they need to be. Met-Review includes the Health Care Help Line, a telephone information service designed to educate plan participants on how to best use their health benefit plan.

- o Pre-screening of selected procedures to be performed in either inpatient or outpatient settings.

The MetLife® Second Opinion Programs and the Managed Care Precertification list address this.

The MetLife® Surgical Necessity Review program is designed to help evaluate the medical necessity of proposed surgical procedures as required by the plan participant's health benefit plan. The MetLife® Procedure Evaluation Program builds on the Surgical Necessity Review program to include a prospective review of certain invasive diagnostic procedures in addition to proposed surgical procedures as required by the plan participant's health benefit plan. Invasive diagnostic procedures include tests such as colonoscopy, cardiac catheterization, gastrointestinal endoscopy and many others. These procedures are not routine tests such as blood tests, EKGs, x-rays and Pap smears. Criteria for more than 40 procedures have been developed. These procedures are targeted because they are known to be performed frequently and are generally expensive.

Managed care plans, including the in-network feature of Point of Service plans and Point of Enrollment plans (that is, MetLife HMO only or Multi-Option Lock-in with MetLife HMO or Exclusive Provider Option (EPO)), require that the Primary Care Physician (PCP) call the Medical Management Center for precertification of medical necessity prior to the delivery of certain services. The following services must be precertified prior to the delivery of service.

1. Referrals to a specialist
2. Hospital in-patient admission, including in-patient rehabilitation (notification within 48 hours of emergency admission or next business day of emergency admission)**
3. Procedures performed in a hospital-based outpatient facility or an accredited free-standing outpatient surgical facility or whenever a facility fee is charged**
4. Endoscopies, except proctosigmoidoscopies, when a facility fee is charged**
5. In-patient and out-patient mental health/chemical dependency services
6. Physical, occupational and speech therapies; cardiopulmonary rehabilitation programs
7. Acupuncture and weight-loss programs if covered under the health benefit plan
8. Sleep studies, MRIs, PET scans, and home intrauterine monitoring
9. Home health care, hospice care or skilled nursing facility
10. Durable medical equipment (DME) over \$100 or equipment rental expected to exceed one month in duration
11. Out-of-plan referrals or services including services provided by any non-contracted provider.

The purpose of precertification is to channel patients to contracted providers and to provide the capability to review the medical necessity of medical services based on generally accepted standards.

*Available from the affiliated MetLife HealthCare Network™ HMO Companies.

**At the time of surgical pre-certification, Medical Management will advise whether an assistant surgeon will be covered as determined by the Claims Department.

- o **Admission review of pre-certified elective admissions within 48 hours**

Met-Review® (Hospital Utilization Review) includes "Admission Review" which evaluates the medical necessity of all emergency admissions and non-emergency admissions that did not receive a Preadmission Review for a determination as to whether the service is medically necessary as required under the terms of the health benefit plan. For non-emergency admissions, MetLife's objective is to determine whether the medical necessity of the admission has been established as required under the terms of the health benefit plan.

- o **Review of emergency and non-routine maternity admissions within one working day of admission.**

Admission Review, a function of Met-Review® (Hospital Utilization Review), evaluates the medical necessity of all emergency admissions and non-emergency admissions that did not receive a Preadmission Review for a determination as to whether the service is medically necessary as required under the terms of the health benefit plan. For non-emergency admissions, MetLife's objective is to determine whether the medical necessity of the admission has been established as required under the terms of the health benefit plan. Generally, the Medical Management Center must be notified of the admission of a plan participant within one business day of the admission. However, the timeframe required for notification may be plan specific.

- o **Patient/provider appeals process for adverse decisions resulting from pre-admission or admission review process.**

When an attending physician and the Medical Director cannot reach an agreement concerning the medical necessity of an admission and/or length of stay, there is a reconsideration process that is available to the attending physician and/or the plan participant. The reconsideration process is described in Attachment A.

Concurrent Review and/or Onsite Review to determine the appropriateness of continued stay. Concurrent review and/or onsite review may include:

- o **Focused Review of conditions and treatments that are known to have higher rates of variation and inappropriateness.**

Local Medical Directors may identify certain diagnoses and procedures which are targeted for more intense scrutiny in both ambulatory and inpatient review. As well, local Medical Management Centers utilize focused studies and clinical audits to focus on items related to local problems identified as part of the quality assurance process.

- o **Follow-up of information obtained during the preadmission review to determine appropriateness of review decisions.**

The Continued Stay Review function of Met-Review® (Hospital Utilization Review) is an automatic extension of the preadmission and admission review process. Our staff evaluate the medical necessity of an extended stay as required under the terms of the health benefit plan. All hospital admissions receive Continued Stay Review except in those states where such review is not permitted. Any clinical information, such as a change in the plan participant's condition or change in treatment, is discussed at this time and noted on the record. Diagnosis, expected length of hospitalization, resources of the facility, and alternative outpatient opportunities are taken into consideration on a case-specific basis in reviewing the medical necessity of an extended length of stay as required under the terms of the health benefit plan.

- o **Patient/Provider appeals process for adverse decisions resulting from the concurrent and/or onsite review process.**

The reconsideration process is available as described in Attachment A.

If the providers do not meet the performance standards of provider profiling:

- o **Analysis of treatment plan performed at periodic intervals.**

All hospital admissions receive Continued Stay Review, which is initiated on the last day of the assigned length of stay until such time as the plan participant is discharged.

- o **Concurrent review of cases that extend beyond the originally assigned length of stay, or the length of stay for the assigned severity of illness or intensity of service required.**

All hospital admissions receive the Met-Review Continued Stay Review. This continues until the plan participant is discharged. If the Utilization Review Coordinator cannot determine that the length of stay extension is medically necessary or if the days requested are in excess of the 75th percentile of the Professional Activities Study (PAS) norms, the case is referred to the Medical Management Center Medical Director. The Medical Director will review the information gathered by the Utilization Review Coordinator and make a determination as to whether the length of stay extension is medically necessary under the terms of the health benefit plan. The Medical Director will contact the attending physician, when reasonably possible, to discuss the clinical indications for the extension before a determination is made that the extension is not medically necessary under the plan.

- o Concurrent review, not including routine maternity admissions, for a specific number of hospital stays.

As noted above, all hospital admissions now receive Continued Stay Review.

Discharge planning to determine the appropriateness of discharge.

Discharge planning may include:

- o Assessment of patient needs in order to arrange for the necessary services and resources to effect appropriate and timely discharge and positive patient outcome.

Discharge Planning, part of Met-Review, Hospital Utilization Review, is the process by which a plan participant's discharge to a non-acute care setting is expedited and coordinated with the administrative assistance of the Utilization Review Coordinator. Discharge planning is the responsibility of the attending physician.

- o Assessment of patients with special needs and resource-intensive diagnoses (for example, traumatic brain injury, spinal cord injury, psychiatric disorders) referred to out-of-state facilities for care to effect appropriate and timely return to in-state care.

During the Met-Review process, the Utilization Review Coordinator will use established screening criteria to identify plan participants who are potential candidates for Case Management services. Potential need for Case Management is identified if the plan participant has a catastrophic illness or injury, or a serious medical and/or degenerative disorder. The Met-Review on-line computer system highlights diagnoses which are appropriate for referral to Case Management.

- o Development of patient/provider appeals process for adverse decisions resulting from the discharge planning process.

The goal of the Met-Review discharge planning process is to expedite and coordinate the patient's discharge. The reconsideration process described in Attachment A is available to plan participants and/or attending physicians.

Outpatient Utilization Review to determine the appropriateness of treatment and/or the procedure in outpatient settings. Outpatient utilization review may include:

- o **Pre-certification of outpatient treatments and procedures that are expensive and/or likely to be used inappropriately.**

For managed care plans, including the in-network feature of Point of Service plans and Point of Enrollment plans (that is, MetLife HMO only or Multi-Option Lock-in with MetLife HMO or Exclusive Provider Option (EPO)), require that the Primary Care Physician (PCP) call the Medical Management Center for precertification of medical necessity prior to the delivery of certain services. The following services must be precertified prior to the delivery of service.

1. Referrals to a specialist
2. Hospital in-patient admission, including in-patient rehabilitation (notification within 48 hours of emergency admission or next business day of emergency admission)**
3. Procedures performed in a hospital-based outpatient facility or an accredited free-standing outpatient surgical facility or whenever a facility fee is charged**
4. Endoscopies, except proctosigmoidoscopies, when a facility fee is charged**
5. In-patient and out-patient mental health/chemical dependency services
6. Physical, occupational and speech therapies; cardiopulmonary rehabilitation programs
7. Acupuncture and weight-loss programs if covered under the health benefit plan
8. Sleep studies, MRIs, PET scans, and home intrauterine monitoring
9. Home health care, hospice care or skilled nursing facility
10. Durable medical equipment (DME) over \$100 or equipment rental expected to exceed one month in duration
11. Out-of-plan referrals or services including services provided by any non-contracted provider.

The purpose of precertification is as follows:

- o To channel patients to contracted providers
- o To provide the capability to review the medical necessity of medical services based on generally accepted standards.

* Available from the affiliated MetLife HealthCare Network™ HMO Companies.

** At the time of surgical pre-certification, Medical Management will advise whether an assistant surgeon will be covered as determined by the Claims Department.

- o **Pre-certification of outpatient surgeries that are frequently performed (for example, tonsillectomy and adenoidectomy, myringotomy).**

The MetLife® Surgical Necessity Review program is designed to help evaluate the medical necessity of proposed outpatient and inpatient surgical procedures as required by the plan participant's health benefit plan. The MetLife® Procedure Evaluation Program builds on the Surgical Necessity Review program to include a prospective review of certain invasive diagnostic procedures in addition to proposed surgical procedures as required by the plan participant's health benefit plan. Invasive diagnostic procedures are tests such as colonoscopy, cardiac catheterization, gastrointestinal endoscopy and many others. These procedures are not routine tests such as blood tests, EKGs, x-rays and Pap smears. Criteria for more than 40 procedures have been developed. These procedures are targeted because they are known to be performed frequently and are generally expensive.

- o **Review of utilization of emergency room services to determine appropriateness of setting.**

As part of Ambulatory Utilization Review, specific prepay edits are incorporated into the claims system. These prepay edits presently include emergency room claims which have not been precertified by a Medical Management Center. Depending on the diagnosis, claims identified by this edit may be referred to a registered nurse for review prior to payment.

- o **Patient/provider appeals process for adverse decisions resulting from outpatient utilization review.**

The reconsideration process is available as described in Attachment A.

Pre- and Post-Payment Claims Review

Prepayment review

- o Validate that hospital, physician and outpatient services claims are not in conflict with or exceeding pre-defined limits compared to claims previously adjudicated.**

The Ambulatory Utilization Review™ Program involves a comparison of services rendered, for which claims have been submitted, to generally accepted medical standards. MetLife uses the HPR Patterns of Treatment® created by Dr. Donald Harrington, as a guide to medical standards. The Patterns are categorized by diagnoses and treatments and provide benchmarks for the maximum expected frequency of physician services, including ambulatory surgery, radiology, lab tests and other such procedures per month, quarter, and year. The Patterns are updated regularly by experts representing various medical specialties; these updates are incorporated into the system several times a year. Depending on the type of health benefit plan, the customer and the provider, AUR may be performed either prospectively or retrospectively.

o Suspension or rejection of claims

Another Ambulatory Utilization Review™ Program system feature known as a "prepay edit" originated with the MetLife® Point of Service product and is used with claims of participating providers within the MetLife POS and HMO networks. Specific prepay edits were selected by a national consensus of the MCSG Medical Directors to be the most effective screens for the most efficient network management. For example, prepay edits include certain emergency room claims, all foot surgery, and multiple surgeries on the same date. Claims identified by these edits may be referred to a registered nurse for review prior to payment.

Post-payment claims review

- o Providers identified for review by referral, practice profiling or rebundling software.**

MetLife has two analytical approaches which review patterns of overutilization or underutilization. The first approach is our Primary Care Physician - PCP - Feedback Report; the second approach is our Ambulatory Utilization Review Program which includes electronic analysis and medical professional review of the appropriateness and frequency of ambulatory services.

- o Contractual obligations of providers to refund payments if requested.**

Yes.

Internal prospective review to determine the accuracy of the decisions made by physicians, nurses, and utilization review coordinators. Internal retrospective review may include:

o Secondary review of questionable reviewer decisions.

The Utilization Review Coordinator compares information about the admission with nationally accepted standards during the review of the medical necessity of the planned admission. If there is any question, the Medical Management Center Medical Director will review available information regarding the medical necessity of the hospitalization and make a determination as to whether the service is medically necessary as required under the terms of the health benefit plan. A determination that a planned admission or continued stay is not medically necessary under the terms of the health benefit plan is only made after discussion, when reasonably possible, with the attending physician. As well, Medical Management Center Managers, Associate Managers and Senior Utilization Review staff are available to clarify policy or procedure questions.

- o **Audit of randomly sampled cases for accuracy and consistency of reviewers' judgements.**

MetLife's Medical Management Programs are audited on an ongoing basis. The national Audit Committee for Medical Management Programs is responsible for the ongoing development and implementation of these audits and the selection of audit teams. The audits are designed to evaluate staff conformance with national policies and procedures, and to evaluate the accuracy and consistency of reviewers' judgements.

Currently Medical Management Programs are audited as follows:

- o The annual on-site audit at each Medical Management Center; conducted by the national Medical Management audit team.
- o The national monthly audit, conducted by designated Utilization Review Coordinators from various Medical Management Centers. Currently this process involves specific review of computer records from the:
 - Met-Review® (Hospital Utilization Review) program,
 - Case Management program,
 - Mental Health and Chemical Dependency Hospital Utilization Review program.
- o The local monthly audit, conducted at each Medical Management Center, under the direction of the Manager of Medical Management.

Each audit uses a detailed audit tool and includes a report of the results. Compliance with national policies for each category identified in the audit tools is quantitatively expressed by percent.

Drug Utilization Review to determine the accuracy and appropriateness of prescription medications. Drug utilization review features may include:

Attached is an extract of our proposal wording which addresses these concerns. There may be a terminology issue. Concurrent and prospective review generally are considered the same. In terms of Montana's plan, its prospective review is our concurrent review.

Our wording, however, does address the issues Montana outlines:

- 1) Concurrent drug utilization review: this focuses on drug review while the patient is in the pharmacy. It primarily addresses situations in which the prescribed drug may cause a problem.
- 2) Retrospective drug utilization review: this reviews historic drug use data at the patient and physician levels. Effects of these programs are seen over time. Changing prescribing patterns takes time and involves patient and physician education efforts.

Montana also suggests the use of a formulary. Metropolitan does not now employ a formulary. We are in the process of evaluating the services of a number of formulary vendors and may adopt one.

Last year, we negotiated a contract with PCS Health Systems, Inc. We now subcontract to PCS the claim payment and data management functions which facilitate the application of these programs. Previously, we used the services of another outside vendor to provide Retrospective drug utilization review. We currently do not offer Concurrent drug utilization review.

DRUG UTILIZATION REVIEW

Drug utilization review (DUR) is an essential component of quality assurance and cost management. DUR evaluates drug usage measured against predetermined standards with the goals of improving care, measuring results, managing costs, and ensuring effective drug usage. Improper or mismanaged drug usage can have serious, but often hidden consequences. Some studies estimate that up to 18% of all hospital admissions are drug related.

PCS developed both its concurrent and retrospective DUR systems, its QUANTUM Alert and QUANTUM Plus products, respectively. Currently, PCS serves more than 450 customers with DUR, providing coverage for 4.5 million patients. PCS's DUR programs are designed to ensure that the patient receives the right drug, in the right amount, at the right time. These programs are based on comparative analysis with algorithmic edits or bench marks.

Concurrent DUR

The concurrent DUR system works through the MediMET network point of service device. It advises the pharmacist, within 30 seconds, of potential problems with the drug they are about to dispense. Concurrent DUR checks for excessive and over and under utilization, duplications in drug therapy and potentially dangerous drug reactions. The message to pharmacist also advises the level of

concern. Only the most severe interactions result in payment denial.

However, this can save lives. For example, a patient takes Coumadin, prescribed by a cardiologist for heart condition. Because of chronic headaches, the patient sees a family physician and receives a prescription for Fiorinal, a painkiller containing aspirin. Taken together, Coumadin and aspirin can cause serious, perhaps even fatal, bleeding complications. The concurrent DUR system warns the pharmacist of this serious drug interaction.

Savings from concurrent DUR average 4% to 5% of the total claim costs for the drug benefit programs. The average savings return on fees assessed for concurrent DUR services has been more than 10 to 1.

Retrospective DUR

Retrospective DUR focuses on physician and patient activity, their past drug use problems and changes that can be made in future drug use. Retrospective DUR is based on the evaluation of drug data after drugs are dispensed using the drug history file and a therapeutic criteria data base. Metropolitan corresponds directly with physician to attempt to change prescribing patterns or to alert them to potential problems.

Clinical Databases

The clinical drug databases that support PCS' DUR services are developed and maintained by PCS' professional staff with input from expert clinical consultants to PCS. Certain criteria and databases are derived from clinical drug knowledge bases maintained by Medi-Span. Medi-Span databases consist of up-to-date clinical drug data which are independently developed and validated, reviewed by an expert clinical panel, and regularly updated.

Information sources used to develop PCS' clinical DUR databases include the American Hospital Formulary Service (AHFS), AMA Drug Evaluations (AMA-DE), USP Dispensing Information (USPDI), manufacturer Information, clinical Experience, peer-reviewed medical and pharmaceutical literature.

Drug History File

Both the concurrent and the retrospective DUR systems scan every prescription for each patient and develop complete drug history profiles for analysis. Each patient's drug history profile developed by the DUR systems is a completely integrated drug profile which includes every prescription processed for the patient by PCS, regardless of where the prescription was dispensed, and regardless of the processing mode (on-line, batch, or direct patient-submitted claims).

This gives PCS the ability to analyze for drug conflicts using complete integrated drug profiles from the entire MediMet network

including any mail order pharmacies whose prescriptions are processed by PCS, and to provide MediMET pharmacists, who are telecommunicating prescriptions real-time with PCS, (including mail order pharmacies), with information necessary to coordinate each patient's complete drug therapy during the dispensing process.

Integration of Mail Order and Retail Claims Experience

PCS is capable of establishing an concurrent DUR electronic information link with mail service vendor pharmacies that have the requisite hardware and system. This link enables the mail order pharmacy to submit prescriptions to the PCS on-line system which then adjudicates the claim and passes the information to an integrated history file. Thus, each patient's claim history is comprehensive and includes every prescription processed for the patient by PCS regardless of whether the prescription was dispensed at a network pharmacy or via mail order.

CONCURRENT DUR SYSTEM

The concurrent DUR system alerts pharmacists of inappropriate medications before they are dispensed at the point of service. Also, analysis of the DUR edit failures can identify important drug use patterns in a program participant population.

On average, the concurrent system detects potential drug conflicts and other DUR problems in approximately 9% of claims. Of

this 9%, 3.5% are denials for excessive utilization, and the remaining 5% to 6% are clinical drug conflicts.

PCS's concurrent DUR system eight edits as follows:

Excessive utilization

- Early refills or excessive prescription filling behavior
- A drug is requested before previously dispensed quantities of the same drug are exhausted or nearly exhausted
- Provider "shopping" to obtain multiple prescriptions for the same drug

Drug-drug interactions

- Potentially dangerous or contraindicated drug combinations
- Drug combinations which require special monitoring or dosage alterations of one or both drugs to maintain drug efficacy or safety

Therapeutic duplications

- Two different drugs from the same therapeutic class or with similar therapeutic uses or effects
- Two different strengths or dosage forms of the same drug

Insufficient drug doses

- Drug doses which are less than a suggested minimum daily dose and may be ineffective

Excessive drug doses

- Drug doses which exceed a suggested maximum daily dose and may be toxic

Drug-age conflicts

- Use of drug which may be contraindicated by the age of the program participant

Drug-pregnancy advisories

- Use of drug with a high birth defect risk by a female patient in the child-bearing age range, who may be pregnant

Drug-disease contraindications

- Use of a drug which is contraindicated by a concurrent disease or medical condition of the patient.

DUR Intervention and Alert Messages

Only the excessive utilization edit causes a claim denial. If a prescription claim fails this edit, the claim is denied, and the pharmacist receives an on-line message indicating claim denial and an "Excessive Utilization" alert.

In certain instances, a claim which is denied for excessive utilization may actually represent appropriate drug therapy; the early refill may be necessary because of an increase in dose, change in prescribing instructions, etc. In these cases, based on

professional communication from the pharmacist to the PCS Pharmacy Help Desk, the denial may be overridden, allowing payment of the claim.

DUR problems detected by the other seven edit systems do not affect claim payment, but result in transmission of a warning or alert message transmitted at the time of dispensing to the pharmacist as part of the paid claim response from PCS. DUR messages are specifically formatted to provide concise conflict or alert information to the pharmacist concerning the prescription being dispensed. In the case of a conflict between the current prescription and another drug being taken by the program participant, the name of the other drug is included in the message.

Real Time Support

PCS maintains detailed on-line claims history and DUR activity information to enable real-time feedback on provider inquiries, support DUR problem research, and provide multiple DUR alert message detail information. This information is provided through the Help Desk.

RETROSPECTIVE DUR SYSTEM

PCS's QUANTUM Plus retrospective program integrates DUR analysis and profiles of both the physician and the patient. The program is designed to achieve significant improvements in pharmaceutical care through managing inappropriate prescribing and drug use behavior

and by focused physician education. Improvements in pharmaceutical care can reduce unnecessary health care resource expenditures related to inappropriate care, including unnecessary hospitalizations and outpatient health care services.

Physician DUR Analysis

The retrospective DUR program uses clinical and qualitative criteria, and exceptional quantitative parameter analysis, to identify exceptional or inappropriate prescribing practices. Prescribers are analyzed to determine normative parameters as well as practices inconsistent with established drug use criteria and standards. Prescribers are then compared with their peers on a geographic and medical specialty basis to identify outliers, exceptional prescription activity, and patterns of inappropriate prescription care.

Exceptional prescription activity and patterns of potentially inappropriate prescription care are monitored as follows:

Exceptional Prescription Activity

Exceptional quantitative drug use is identified by measuring each prescriber's individual prescription drug behavior against normative values for several quantitative parameters.

Quantitative parameters analyzed for exceptional drug prescribing or dispensing behavior include:

- Prescription utilization:
 - average number of prescriptions per patient
 - average number of different drugs per patient
 - average cost per prescription
 - average prescription cost per patient
- Generic drug use and DAW rates:
 - percentage of prescriptions for multisource brand drugs which include a DAW override code
- Controlled substance use:
 - percentage of patients for whom controlled substance prescriptions are written/dispensed
 - average number of controlled substance prescriptions per patient
 - average number of different controlled substance drugs per patient

Inappropriate Patterns of Care

Prescribers are analyzed using focused drug use criteria, algorithms and therapeutic drug selection parameters to detect potentially inappropriate drug prescribing and pharmaceutical care practices. Prescribing behavior and practices analyzed by the DUR system include:

- Inappropriate and high risk drug therapies
- Cost-ineffective therapeutic drug selection practices
- Excessive duration of therapy

- Therapeutically duplicative/redundant prescribing practices
- Inappropriate drug dosing practices

Patient DUR Analysis

QUANTUM Plus uses clinical and qualitative criteria, and exceptional quantitative parameter analysis, to identify exceptional or inappropriate drug use behavior by patients. Patients are analyzed to determine normative parameters as well as drug use inconsistent with established drug use criteria and standards, and then compared with peer patient populations on an age/sex basis to identify outliers, exceptional prescription activity, and patterns of inappropriate drug use behavior.

Exceptional prescription activity and inappropriate drug use behavior are monitored as follows:

Exceptional Prescription Activity

Exceptional quantitative drug use is identified by measuring each patient's individual prescription drug behavior against normative values for several quantitative parameters.

Quantitative parameters analyzed for exceptional prescription activity include:

- Prescription utilization:
 - number of claims
 - claim dollars
 - number of different drugs
 - number of controlled substance claims
 - number of different controlled substance drugs
 - number of early refill denials

Inappropriate Drug Therapy

Patients are analyzed using focused drug use criteria and algorithms to detect potentially inappropriate or high risk drug therapies or behavior. Drug use patterns analyzed by the DUR system include:

- Controlled substance abuse
- Excessive duration of use of selected drugs or drug classes
- Late refill behavior, underutilization, and non-compliance with chronic maintenance drug therapy
- Provider shopping behavior

Retrospective DUR Intervention

Profiles are produced for each physician and each patient for whom exceptional prescription activity or patterns of inappropriate or high risk prescribing or drug use behavior are identified.

In addition, PCS provides full DUR intervention support and management including professional profile review and support services; prescriber education and follow-up programs; and other retrospective DUR support.

Intervention and education support services include automated patient and provider drug profiles, professional profile review and technical support, automated patient-specific and provider-specific intervention letters, automated DUR problem and intervention tracking, and provider education and follow-up programs.

Intervention letters are generated automatically based on DUR analysis and findings. The letters are patient-specific, provider-specific, and standardized and will identify the DUR problems or issues detected for the particular physician or patient.

Utilization Management Tracking to determine if utilization management strategies are effective and should be continued and/or modified. Tracking may include:

These responses indicate our technical capability. That is, a "yes" response indicates that we have the ability to produce and report the requested data. Such a response does not necessarily mean that a specific standard report currently exists for the requested data. (This information was provided by Tom Bice, MCG Health Services Policy and Research. If you have questions, you may reach Tom at 203 - 454 -6106.)

Collection, analysis and interpretation of health care statistical data to determine effectiveness of cost management measures, to design benefits and to better manage care

- Compare all hospital utilization rates - yes
- Examine provider practice and referral patterns - yes
- Compare claims data to norms - yes
- Analyze monthly utilization - yes
- Conduct health risk appraisals - no
- Assess quality of care - (?) - need to further define "quality")

Processes to measure ongoing effectiveness of utilization review programs and eliminate ineffective procedures

- For hospitals: for example, cost per review, average cost per hospital stay, average length of stay, percent of hospital days determined inappropriate based on a sample of medical records, estimate of percent of hospital inefficiency - yes
- For providers: for example, cost of review, number of services denied or reduced - yes

In aggregate: for example, cost-effective substitution of services, advantages of alternative benefit programs, overall insurer savings - yes. (- Savings Reports for Medical Management Programs - such as Met-Review and Case Management)

Processes to disseminate findings from utilization management efforts and to use findings to restructure benefits and refine further utilization management techniques - yes

Tracking of utilization review outcome data annually for effectiveness

- Number of reviews - yes
- Percent cases referred for physician review, appealed, overturned - yes
- Average length of stay (ALOS) in days - yes
- Change in ALOS from year to year - yes
- Admissions / 1000 - yes
- Outpatient procedures / 1000 - yes

Tracking of mental health / chemical dependency utilization

- Number of days / 1000 - yes
- Average adult, adolescent inpatient lengths of stay (days) - yes
- Average number adult, adolescent outpatient psychotherapy visits per patient - yes

Reporting cost and utilization experience, savings, and other utilization management activities, as well as sharing information with employers and other purchasers and patients. yes

Attachment A.

RECONSIDERATION OF UTILIZATION REVIEW DECISIONS

These procedures set forth the reconsideration process to be followed when the attending physician (in-network) and the attending physician and/or plan participant (indemnity or out-of-network) do not agree with a determination that certain planned services do not meet the medical necessity requirements of the plan. This reconsideration process is only available in advance of the submission and determination of a claim for benefits. If this process is pursued when available, it is a reconsideration process in addition to the right to appeal a claim denial.

If the attending physician and/or plan participant disagrees with the medical necessity determination concerning a planned treatment or service, the plan participant and/or the attending physician (indemnity or out-of-network) or the attending physician (in-network) can request reconsideration of the medical necessity determination. Such oral or written requests for reconsideration shall be directed to the local Medical Director for review.

If the local Medical Director finds no reason to alter the original medical necessity determination, the request for reconsideration is forwarded to another MetLife Medical Director for review. This second Medical Director shall review and respond to the request for reconsideration within (2) working days. The response shall be in writing to the local Medical Director. The local Medical Director shall respond in writing to the attending physician (indemnity or out-of-network) with a copy to the plan participant or the attending physician (in-network) requesting reconsideration and provide a copy of the response to the Medical Director who provided this reconsideration review.

Local Medical Directors shall maintain a log of all such reconsideration reviews. Local Medical Directors shall submit logs to the Regional Network Director on a quarterly basis and also provide copies to the legislative consultant, Medical Management Center to facilitate reports required by both statute and clients.

In the event the local Medical Director's original medical necessity determination is upheld, the plan participant and/or attending physician (indemnity or out-of-network) and the attending physician (in-network) shall be offered the opportunity for further reconsideration. The request for further reconsideration shall be directed, via the appropriate Medical Management Center, for further review, by a Zone Medical Director or an independent peer review agency as deemed appropriate by the local Medical Director, or as required by the provisions of a particular health benefit plan.

o **Other innovative strategies in utilization management that address appropriateness, reductions in health care costs and quality of care.**

All of our medical management programs are continuously assessed to evaluate effectiveness and identify areas for potential improvements. Within the past year, important enhancements that were implemented or planned include:

- The Case Management program was enhanced to include electronic on-line referral of cases that are identified during claims processing. Previously all claims referrals were made using a paper report. The new enhancement also provides the opportunity for case management evaluation of referrals that have required only outpatient services. Outpatient claims are identified using service codes, diagnosis and dollar thresholds. Areas identified for referral as potential high dollar claims are Home Health Care, Durable Medical Equipment, CAT Scans and MRIs, Psychiatric Services, Dialysis, Speech, Physical and Occupational Therapies.
- MetLife developed a comprehensive educational booklet, "Healthy Pregnancy," designed to answer frequently asked questions about pregnancy which is sent to all MetLife® Healthy Pregnancy Program™ participants. Also, an enhancement to the program was implemented to identify potential participants through Claims Department referral, whereby claims for specific tests and procedures that have been identified as being associated with pregnancy will be flagged for referral to this program. In 1993, a new pilot program for pregnant women who may be at increased risk for premature labor and delivery includes a home educational visit by a perinatal nurse, to be arranged by a MetLife contracted national ancillary perinatal provider. These women at increased risk will also be contacted by the Healthy Pregnancy Program Coordinator monthly throughout the pregnancy.
- The Centers of Quality™ program was enhanced by centralizing the case management of all transplant cases in a specialized Transplant Coordinator Unit. This centralization will allow this specialized unit to develop a closer working relationship with both the Technology Review Unit and the Centers of Quality facilities. As well, payment of transplant claims will be consolidated from 26 claims offices to four and improved and standardized methods have been implemented to measure the quality and cost of the Centers.
- The Medical Review System developed by Value Health Sciences came into use to enhance surgical necessity review for the MetLife HMO Plans in selected sites.

ALTERNATIVE MECHANISMS FOR PAYMENT TO PROVIDERS

Hospitals

We utilize several payment mechanisms for hospitals in our managed care networks. The methods different by geographic site, based on competitive pressures in the local medical community, state regulations concerning hospital reimbursement, and the geographic coverage requirements our Network Adequacy Model determines for member access.

Currently, hospital payment arrangements include:

- o Per Diem: the provider receives a fixed amount for each day the patient remains in the hospital, regardless of the number or types of services provided. This is our preferred and most common approach.
- o Negotiated Discounts: the provider agrees to accept discounted fees for services provided.
- o Per DRG: the provider assumes the financial risk of managing the care for an individual, regardless of the length of stay, for a fixed amount based on the diagnosis.

At some facilities we may use a combination of these payment mechanisms. At some facilities we may have volume-sensitive arrangements.

At our Centers of Quality we typically negotiate a global fee for the entire service package.

At non network hospitals, we generally do not have negotiated fees, other than perhaps some prompt payment discounts.

Physicians

Current the primary physician payment mechanisms in our networks are:

- o Fee schedule with no withhold
- o Fee schedule with a withhold
- o Capitation (HMOs only - not all HMOs)
- o Discounted fee-for-service (rare)
- o Global case fee/per episode fee (typically only for maternity care)

In the future we expect to expand capitation and per case/episode fee arrangements.

Ancillary Providers

- o Per Diems: for home infusion and perinatal care
- o Case Rate: for rehabilitation facilities. Payment is at one of four levels based on the severity of the injury.
- o Fee schedules: for durable medical equipment (100 common items are covered by our fee schedule) and laboratories.
- o Discount of Billed Charges: for durable medical equipment not covered by our fee schedules.

Electronic Claims Submission

MetLife is a member/owner of the National Electronic Information Corporation (NEIC) one of the nation's largest networks/clearinghouses for electronic claims submission. MetLife is continually increasing the volume of electronic claims submissions to help lower administrative costs. We are currently participating in the public/private Workgroup on Electronic Data Interchange (WEDI) which is developing industry standards for electronic eligibility, claims submission and claims payments.

Third Party Liability/Coordination of Benefits

MetLife can electronically exchange data with Workers Compensation carriers to identify any possible duplication of payment. Claim selection criteria is based on procedure and diagnosis codes which frequently involve a work related illness or injury. Claims personnel are then able to research the specific files and pursue reimbursement when appropriate.

A number of mechanisms are in place to monitor and verify all accidental injury claims. The system to investigate Third Party Liability is automatic. Medical benefits are first paid and steps are taken to determine other party liability. The procedure amounts to the filing of a lien against the proceeds of any award or settlement to recover the medical benefits paid.

CHAMPUS coverage is recorded on the individual claimant's file. In most cases, CHAMPUS is secondary to Group coverage.

MetLife obtains other party liability information at the time the claim is processed. History is maintained on the system as are dependent eligibility records. Retiree and retiree spouses' information is screened for evidence of active employment with coverage elsewhere.

Third Party Liability/Coordination of Benefits savings levels are based upon the size of the case and MetLife's experience; actual results are discussed with the customer.

Utilizing a non-duplication clause may decrease the level of savings by encouraging employees to select one plan, drop the other plan, possibly creating primary liability for our customer and eliminating our customer's potential of being the secondary carrier.

Quarterly reports are available which provide the customer a detailed recap of Third Party Liability/Coordination of Benefits claims processed.

Coordination of Benefits information is monitored, updated and maintained electronically. Information is verified routinely during claim processing. Eligibility of the employee, dependent, retiree, COBRA continuant, etc, is generated for approver review. Generally, policies issued by MetLife contain a COB or Non-duplication provision. As secondary payor, the secondary plan pays whatever it would have paid had it been primary less whatever the primary plan paid. Coverage information can be obtained from client's eligibility tapes and detailed claim reports are provided to the customer for review.

COB information files are updated automatically during the claim process.

MetLife's Customer Service Survey completed in December 1992, rated timely response to customer inquiry as high as 91% and averaged 80% total for all offices.

Every group claim office is expected to meet MetLife's standards for turn-around time for all types of claims, whether with or without COB; namely, 80% of all medical claims will be processed within 10 working days. Our on-going 12-month studies show the offices consistently meet or exceed these corporate standards.

Clients with non-duplication COB savings levels = 4.8 to 5%

Clients with traditional COB savings levels = 5 to 5.2%

MetLife is a forerunner in health care data collection information and management. As stated in the Integrated Managed Care System manual,".....with the continuing escalation in medical care costs, employee group health insurance has become a major expense. MetLife recognizes the need to make health care coverage more cost-effective, and to achieve this goal the company has adopted and introduced many innovations in coverage and in health care management costs....." IMCS automatically alerts the claim reviewer to the existence of other coverage during processing.

Other coverage information can be obtained from the customer's eligibility tapes. This information can be reviewed and updated on a regular basis.

Automatic interface of group health and dental coverage to share other party liability information.

Routinely send other coverage query letters or cards to group health participants.

Medicare Crossover Part B, the process where medical claims for Medicare enrolled individuals, who also have secondary group plan coverage, are submitted only once, directly to the Medicare carrier, (who in turn transmits the settlement data electronically to the secondary payor), is gaining acceptance by more customers.

Establishment of a Subrogation Specialist in each zonal claims office increases reimbursement of medical benefits paid when there is settlement by a third party.

Topic: Administrative Methods

- **Acceptance of standardized claim forms**
 - HCFA 1500, Health Insurance Claim Form for medical claims
 - ADA Dental Form for Dental Claims
 - HCFA 1450 (aka UB-82, UB-92) Universal Billing form for hospital claims
- **Acceptance of common coding schemes**
 - CPT - Common Procedural Terminology
 - HCFA - Common Procedure Coding System (HCPCS)
 - ADA - Dental Procedure Codes
 - Revenue Codes
 - National Drug Codes (NDCs) for Medimet Drug Plan (Move to expanded use across all lines of coverage)
 - ICD-9 - CM - International Classification of Diseases 9th Revision, 4th Edition, Clinical Modification (Diagnosis and Procedure Codes)
- **Collection of information to support a unified data base**
 - Acceptance of specific patient and provider identification numbers
 - Employment and Eligibility Status
 - Profile of actual provider fees to establish Reasonable and Customary charges
 - Provider File Maintenance including provider type, specialty, and accreditation information
- **Strong proponent of WEDI (Workgroup for Electronic Data Interface) and the ANSI (American National Standards Institute) process**
 - **Electronic Standardized Formats**
 - Enrollment - Using ANSI 8-34 dataset
 - Eligibility - Using NEICs Healthcare Information Network (HCIN)
 - Claims submission - Through NEIC
 - Payment and Remittance - Using ANSI 8-35 through NEIC

- Internal performance monitoring and measurable claims processing standards
 - Ongoing review of administrative costs
 - Specific Standards established governing timeliness and responsiveness
 - Claims Processing
 - Adjustments
 - Mail/Correspondence
 - Telephone Service
 - Accuracy
 - Accuracy Assurance Review (AAR) program whereby 2% of every claims approver's production is randomly selected each week for review
 - Specific Standards to measure claims processing accuracy in three categories
 - Payment
 - Customer Service
 - Coding
 - Electronically generated Management Reports target specific claims payment activity for review, i.e. high dollar payments, fees in excess of reasonable and customary allowances, etc.
 - Quality
 - The regular AAR discipline supports an ongoing Error Prevention Procedure using quick feedback and self correcting techniques
 - Regular meetings for both management and claim paying personnel are held in every claim office to discuss opportunities for improvement and appropriate action plans
 - "Teams for Action" bring employees together that usually do not work as a team to improve service
 - Service Improvement Teams
 - Natural Work Teams
 - Local Assembly
 - Customer Satisfaction Surveys are distributed 3 times each year to approximately 80,000 claimants per distribution period
 - Staffing to evaluate overall performance

Process to prevent and detect fraud and abuse and seek criminal prosecutions against providers and patients who commit fraud.

Policy

MetLife has committed significant resources toward combatting insurance fraud throughout the Group Department. Evidence of this is apparent in the formation of the Health Care Fraud & Abuse Unit (Central Fraud Unit), within the Group Claim Operations Department.

The Central Fraud Unit is responsible for providing department-wide direction aimed at detecting and preventing fraudulent claim activity. Where warranted, steps are taken to prosecute those responsible for the submission of fraudulent claims and to recover any inappropriate payments which may have been made. Further, the Central Fraud Unit serves as the Group Department liaison to state insurance fraud bureaus and other official agencies, such as the Federal Bureau of Investigation, United States Attorney's Offices, Postal Inspector's, etc. Additionally, the Central Fraud Unit provides reports which document the savings generated and recoveries made, as a direct result of Group Department Fraud efforts. The continued education of consumers and claim approvers, on fraud issues, is another responsibility of this specialized unit.

Definition

Health care fraud is an intentional deception or misrepresentation that the perpetrator makes knowing that the misrepresentation could result in some unauthorized benefit to the perpetrator or to some other party.

The most common types of fraud involve a false statement or misrepresentation that is critical to the determination of benefits payable.

In the area of health insurance, fraud includes, but is not limited to:

1. Billing for services, procedures, and/or supplies that were not provided;
2. Misrepresenting any of the following for purposes of manipulating the benefits payable:
 - a. The nature of services, procedures, and/or supplies provided;
 - b. The dates on which the services and/or treatments were rendered;
 - c. The medical record of service and/or treatment provided;
 - d. The condition treated or diagnosis made;
 - e. The charge for services, procedures, and/or supplies provided;

- f. The identity of the provider or the recipient of services, procedures and/or supplies.
- 3. The deliberate performance of unwarranted or non-medically necessary services for the purpose of financial gain, in lieu of insurance deductible and/or copayment collection.

The following general practices, while not necessarily fraudulent, can constitute abusive practices.

- a. Unbundling - services billed separately to misrepresent or overstate the amount of services actually provided.
- b. Uncoding
- c. Ordering unnecessary tests, treatments and/or referrals
- d. Overutilization, either in duration or frequency of treatment
- e. Billing for questionable/unproven treatments

Fraud Detection

MetLife's Fraud Prevention & Detection program is multi-faceted and may be found working, procedurally and electronically, throughout the claims operations. While specific procedures and programs are updated continuously to meet the challenges of the changing health care environment, suspicious claims may be identified through any of the following sources:

Claim Approvers

Claim Approvers are trained to identify suspicious claims. They are provided a comprehensive list of fraud indicators for reference. Additionally, the system flags the Claim Approvers when an aberrant provider is involved and provides any special instructions. Claims processing is monitored through various quality control programs. Suspicious claims are forwarded through the Office Fraud Coordinators to the Central Fraud Unit for review.

Provider Flags

These are an integral part of prepayment identification of potential fraud. Providers who have an aberrant history of claim submission as well as those who are currently under investigation are "flagged" on the system with instructions to call the Health Care Fraud & Abuse Unit staff for guidance in processing the claim. Benefits cannot be paid to those providers without referral to a Fraud Coordinator, Senior Approver or Supervisor. Additional Flags are available whereby the Fraud Unit may give special handling instructions to the Approver for claim payment to a particular provider. Ambulatory Utilization Review (AUR) also flags providers with aberrant practices for review by AUR. When appropriate, comments regarding these providers are shared with the Central Fraud Unit for follow up.

Foreign Claims

Foreign Claims, particularly from Mexican providers, are closely monitored including those foreign providers who utilize U.S. billing addresses. Trained investigators are sent to these areas to ascertain whether there is in fact a hospital or medical facility in existence. Further investigation may include interviews of on-site personnel and request and review of medical records. Many of these claims are denied when it is found that services have not been performed as billed.

Late Hospital Charges

Charges from these hospitals are carefully reviewed to determine their validity. A lucrative partnership between the provider and "auditing or revenue recovery firm" is often arranged to "discover" undercharges or services not previously billed. These firms are usually compensated by a percentage of the monies recovered. On review of these "audits" we usually find that the charges are a result of fragmenting previously reimbursed services and are not valid. The patient is not liable for these bills and they are denied.

Coding Fragmentation

An example of an abusive practice whereby a provider "unbundles" the billing for services to misrepresent or overstate the amount of services actually provided. Our Coding Fragmentation Review Program (CFRP) electronically identifies fragmented charges on submission and automatically rebundles and pays them under the appropriate code.

Ambulatory Utilization Review (AUR)

This is another program that has been very successful in identifying and preventing fraud and abuse. It's primary focus is addressing the overutilization of outpatient services. In the course of this review, claims are often found that warrant review by the Central Fraud Unit. The AUR nurses and Fraud Unit personnel work together to effectively monitor the activities of the provider community.

Management Claim Payment Reports

The supervisor of each claim processing team, Office Fraud Coordinator and Central Fraud Unit review these reports daily to identify suspect claims. These include:

Large Payment Report - This report lists payments of \$5,000 or greater.

Third Party Payment Report - A report that lists claims processed for other entities not normally payable through the claims system.

Provider Fraud Address Report - This report provides a listing of all claims where the first five characters of the provider's and insured's address are an exact match.

Flagged Provider Override Report - This report provides a listing of all claims where benefits have been issued to a provider under "flagged" status.

Group Health Care Fraud and Abuse Databases

The Central Fraud Unit databases record and track all cases under review by the unit. The databases also compute actual costs, savings, recoveries and preventable loss.

Law Enforcement Agencies

The Central Fraud Unit deals actively with State Insurance Departments, State/Federal Law Enforcement agencies, and various public health funding agencies, particularly concerning cases with criminal prosecution for fraud. Such cases have involved the FBI, the US Postal Service, various State/Federal Inspector Generals, local Police and District Attorneys.

Industry Sources

In 1985 MetLife helped to found the National Health Care Anti-Fraud Association and currently serves on its Board of Governors. The National Anti-Fraud Association has established a database of aberrant providers and participating members may have access to it.

System Safeguards

MetLife's claim system, along with appropriate office procedures, provide a multitude of effective checks and balances for the timely and accurate processing of valid claims.

Responsibilities

Claim Approvers have the following responsibilities:

- Identify suspicious claims based on their awareness of specific fraud indicators.
- Refer these suspect claims to the attention of the Office Fraud Coordinator.

Office Fraud Coordinators have the following related responsibilities:

- Review and investigate fraud referrals from claim approvers
- Refer suspect fraud claims to Central Fraud Unit.
- Maintain log of all cases investigated and their status.
- Track savings in all areas of fraud detection for their office and for reporting to Central Fraud Unit.
- Follow up on any cases referred to Central Fraud Unit.
- Review daily management reports.

Central Fraud Unit has the following responsibilities:

- Investigate claim referrals from various sources in conjunction with Corporate Law Department.
- Educate approvers, coordinators and consumers.
- Maintain and analyze Group Health Care Fraud & Abuse databases.
- Monitor activity of Office Fraud Coordinators.
- Verify that external communications are consistent and approved by legal department.
- Request and track restitution payments.
- Communicate and comply with state agencies and industry networks.
- Review management reports.
- Design new reports on an on-going basis to assist in fraud detection activities and work with systems personnel to implement.
- Monitor, revise and update file of aberrant providers who are flagged by the claims system.
- Work with Corporate External relations to publicize the Central Fraud Unit's activities.
- Identify new indicators to be added to claims systems as business warrants.

Ongoing training of personnel across major functional areas on recognition of potential fraud & abuse situations.

The Health Care Fraud & Abuse Unit (HCFA) of MetLife is actively engaged in an expanded education program of our claim processors referred to as Approvers and Office Fraud Coordinators. A section on fraud and abuse has been added to our Approver training manual and training sessions for Approvers are held yearly.

Approvers are instructed on how to identify suspicious claims based on their awareness of specific fraud indicators and how to refer these suspect claims to the attention of the Office Fraud Coordinators. The following examples are Indicators of Fraud:

- Signature of Employee and/or Provider is not on the Claim Form.
- Handwriting in Provider's section of Claim Form matches Employee's.
- Photocopies instead of Originals of Claim Forms and Bills are submitted.
- Missing Records, Bills, etc., relating to the Claim.
- Lack of supporting evidence (Hosp./Anesthesia Bill) for Surgical Claim.
- Large number of Dependents, or Claimant is recent Enrollee in Plan.
- Additions to listed services in different handwriting, types or ink.
- Alterations of items affixed to the Claim Forms.
- Incorrect spelling or improper use of Medical Terms and abbreviations.
- Insured's or Dependent's age inconsistent with Diagnosis.
- Billed services inconsistent with or not relevant to Diagnosis/Treatment.
- Doctor Bills show many visits, yet no bills in for Rx's or other expenses.
- Drug Bills apparently altered or showing more than \$75 for one Prescription.
- Drug Bills in excess of \$500 with minimal Medical Treatment in the same year.
- Hospital Bills or other claims of large amounts not assigned to Providers.
- Provider cannot be traced or Provider has no record of the Patient.

An extension to the Health Care Fraud & Abuse unit are the Office Fraud Coordinators. Their primary responsibility involves the review of claim referrals from the Approvers. The HCFA unit furnishes continuous training by holding yearly conferences and by providing a manual on fraud and abuse topics.

Education of providers and patients regarding fraud and abuse policies

In addition to educating our Approver staff and Office Fraud Coordinators the Health Care Fraud & Abuse Unit is actively involved in educating our consumers. This is achieved through various methods such as:

Group Snoop Newsletter

In the past year the Central Fraud Unit created and released the first issue of the Group Snoop newsletter. The intent was to further educate the Approver staff on fraud and abuse related topics, however, upon request it is released to our policyholders to further educate them.

"20/20" Segment

The Vice President of Group Claim Operations was recently featured on the television program "20/20". The segment centered on a scheme where dermatologists were billing for acne surgery when in essence they were providing cosmetic facials and chemical peels. The purpose of our Vice President's appearance was to further educate the public about aberrant provider schemes.

Marketing Releases

The Central Fraud Unit has recently begun preparing marketing releases on fraud and abuse issues. The first release dealt with the handling of claim submissions from Mexican providers. Another release is currently being prepared on providers self-referrals to facilities in which they may have a financial interest. These releases are issued to our policyholders.

Process to increase patient's awareness of fraud and abuse and to encourage their participation in efforts to detect fraud and abuse (e.g., enclosures with explanations of benefits mailed to patients)

Benefit Statement Inserts

In an effort to involve our customers/policyholders, benefits statement inserts are sent out to various customers. These inserts remind claimants to read their benefits statement and confirm the services rendered agree with the services listed on the benefits statement. The insert contains an "800" number to report any billing errors or improprieties. In addition, posters reflecting the same message are also available upon request.

Patient Questionnaires

To further combat aberrant provider billing schemes, questionnaires are sent to patients to verify services rendered. The questionnaires also increase patient awareness of the types of services and charges submitted by the provider.

Formal linkage between provider profiling processes and fraud and abuse detection

The Central Fraud Unit is in constant communication with our Claims Planning and Policy area. This area is responsible for the maintenance of our Provider File. All new provider information is verified before being added to the Provider File. The review includes verifying the name, address, tax identification number and license number with the provider. The provider information is then checked against the state licensing board, disciplinary listings and the American Medical Association Directory.

The Health Care Fraud & Unit receives and reviews all state disciplinary listings. The information is then forwarded to the Claim Policy and Research area.



MUTUAL OF OMAHA
COMPANIES

- 5 -

April 5, 1994

Mike Craig
Montana Health Care Authority
28 N. Last Chance Gulch
P.O. Box 200901
Helena, Montana 59620-0901

Cost Management Plans

Dear Mr. Craig

The following is a response to your request for submission of cost management plans. The plan for:

Mutual of Omaha Insurance Company,
United of Omaha Life Insurance Company and
United World Life Insurance Company is described below.
Separate Data Sheets for each company are enclosed.

Integrated Systems for Health Care Delivery

A gatekeeper, HMO product is not currently offered in Montana. However, we are seriously reviewing the legislative and provider environment for feasibility.

We do provide flexible benefit plans that provide the most cost effective services that meet a patient's needs; our plans encourage home health care, outpatient care, and allows for the most appropriate level of care for the sickness being treated.

We currently offer a PPO program to small and large employers in selected sites. Provider credentialing is delegated to local managed care organizations which have agreed to credential in accordance with our corporate standards which are available upon request. Audits are performed of the local organizations at least every two years. Included in the recredentialing process is a review of the provider's practice patterns based on cost and appropriateness based on volume and level of care. Medical Directors individually contact questionable providers to discuss issues and alternatives.

Networks now include only M.D., D.O., and PhD's. - Non physician providers are not currently contracted. National contracts and some local providers are utilized for "bulk" purchasing of items such as DME and prescription drugs.

We are committed to providing our customers with services that will improve the quality of life and health of their employees, while controlling health care costs. Our Healthy Maternity Program promotes healthy pregnancies through early prenatal care, patient education, early identification of risk factors and promotion of healthy lifestyle habits. This value-added service is included in our utilization management program.

We have the Dean Ornish Coronary Reversal Program which is a secondary illness prevention program, currently available at limited sites. Asthma and diabetes are areas that Case Management is focusing on for additional educational programs to prevent progression of illness.

Alternative Mechanisms for Payment to Providers Strategies

PPO hospitals are reimbursed using a combination of per diem allowances and straight discounts from billed charges. The PPO does not include risk sharing since the member has no gatekeeper. PPO plan designs encourage use of contracted providers through lower coinsurance and deductible amounts to the member. "Bundling" software is applied to all claims when processed; not just managed care claims.

PPO physicians are currently reimbursed at a discount from billed charges or a discount for our usual and customary amount whichever is less. We are attempting to get them on a resource based payment system.

Our procedure code evaluation software will help ensure claims are paid properly by eliminating the financial impact of inappropriate billing practices. These practices may include unbundling and billing for incidental or mutually exclusive medical procedures.

Outpatient PPO hospital discounts are strictly a discount off billed charges, however we are attempting to contract for outpatient surgery on a flat fee schedule. Many policies incorporate per occurrence deductibles for emergency room usage.

National and local bulk contracts exist for DME, prescription drugs and IV therapy.

Expenses which are not medically necessary or above the usual and customary amount are denied. Provider charges that consistently exceed usual and customary amounts or whose treatment practices are questionable are identified on the claim paying system for review of all charges received.

Providers are recredentialed every two years with consideration given to their practice patterns and cooperation with managed care program requirements. Feedback is given to the provider throughout the year on practice patterns and survey results.

We are currently operational with an organ transplant network covering lung, heart, heart/lung, kidney, kidney/pancreas, liver, and bone marrow. These providers were selected based on the quality of their total program. Our Medical Specialty Network for organ transplantation services all product lines at the Companies, and will involve benefit enrichments to address the travel and lodging costs for families traveling to regional facilities for organ transplantation. In addition, we are currently developing a centers of excellence program for asthmatics, spinal cord injured, and brain injured patients.

Utilization Management

The Care Review Unit does a focused review of physicians when potential problems are identified. These problems may relate to quality of care issues or failure to comply with utilization management guidelines. While on focused review, the physician's cases are monitored for 1 year.

We prepare statistical reports on managed care network providers to review appropriateness and quality of services for specific diagnostic categories.

Care of the catastrophically ill or injured may be enhanced by comprehensive, coordinated planning. Medical Case Management is a voluntary program that facilitates optimum outcomes by assisting patients in receiving the most appropriate, cost-efficient care. Our case managers work with the patient, their families, physicians, and providers to develop a treatment plan designed to improve quality and efficiency of care while maximizing benefit dollars. Medical case managers can identify alternate care options, negotiate rates, and suggest flexible benefits to enhance the plan of care.

Referrals are received from the Care Review Unit, claims, benefit administrators, our 800 line, underwriting, the insured, and providers. As part of the utilization management process, referrals from the Care Review Unit are identified by diagnosis code and through discharge planning procedures.

Our pre-admission review process applies to all hospitalizations. Medical information obtained from the patient's physician is evaluated according to nationally accepted criteria to determine medical necessity and length of stay assignment. Prospective review is done on select outpatient and inpatient tests and surgeries. This review applies to overutilized procedures with uncertain outcomes.

When our nurse reviewer certifies a case, the patient's physician is advised of the determination during the phone conversation. If the nurse cannot recommend certification, the case is referred to our physician reviewer who calls the patient's physician or provides a recommendation within 24 hours. If the physician reviewer cannot certify a case, the appeal process is offered.

The Care Review Unit provides concurrent review for confinements which extend past the original certification. Our appeals process also applies to the continued stay review.

The Care Review Unit's utilization review nurses refer cases to the discharge planning team to determine the medical necessity of alternative levels of care for patients with short term needs. The discharge planner negotiates rates and costs for nursing care, medications, and supplies.

Discharge planning identifies patients who can benefit from a coordinated approach to hospital discharge and facilitates obtaining medically necessary health services and supplies. Alternative health care services utilized in discharge planning are home health care, extended care, durable medical equipment and intravenous therapy. Additionally, discharge planning can include provisions or physical therapy, speech therapy, and occupational therapy. Discharge planning also involves referral of catastrophic cases to our medical case management team.

Prospective review is available for select outpatient tests and surgeries for large group policyholders. This review applies to overutilized procedures with uncertain outcomes. Our appeals process applies to outpatient reviews.

As a component of our quality process we perform retrospective reviews on 2% of our nurse reviews and 20% of our physician reviews.

Our Health Care Management Department will implement prospective and retrospective drug utilization review as part of its Mutually Preferred Prescription Drug Program in April 1994.

Health Care Management does quarterly reporting that tracks outcome data including total admission review activity, diagnostic categories review activity, and program performance.

Administrative Methods

We accept all standardized claim formats.

All information entered into the claims paying system is available for recall to support a unified data base. The Patterns of Ambulatory Care and Treatment (P.A.C.T.) program uses

Patterns of Treatment criteria to help review the appropriateness of selected outpatient procedures. It provides a medical model which defines acceptable treatment for over 14,000 diagnoses, using more than 7,000 procedure codes. The criteria shows the types of procedures applicable to a health condition and the allowable limit for each procedure. P.A.C.T. accesses our claims data base and provides information showing which service(s) fall outside the accepted treatment pattern criteria. We use P.A.C.T. to facilitate dialogue with physicians concerning treatment patterns, increase control of managed care providers, and identify opportunities for case management and employee education.

We currently accept CPT, HCPCS, ICD-9-CM and ADA coding schemes and are working on acceptance for other common coding schemes.

We strongly support the work of WEDI and other national efforts toward electronic standardized formats. We have adopted the 1994 ANSI standards for transactions of Electronic claims submission, Electronic payment and remittance advice, Enrollment, and Eligibility.

We are currently affiliated with NEIC, we can receive electronic claim information from a variety of national sources provided standard formats are utilized. We can also interface with PC software which is currently being marketed.

Internal procedures are in place to review administrative costs, time of service and also quality and accuracy of the claim processing. An appeal mechanism is currently in place.

Third Party Liability/Coordination of Benefits Strategies

All policies contain a third part reimbursement or subrogation rider. All accident claims are investigated to determine circumstances and third party involvement. Reimbursement is requested where appropriate.

We are exploring external data base review of other insurance/coordination of benefit information.

All claims are investigated for coordination of benefits or other insurance. Other insurance information is captured and updated in our system.

Quality

Provider credentialing ensures that all providers meet specific professional and environmental standards. Hospitals have a quality improvement process in place.

Utilization management quality issues are screened for and identified through inconsistency reporting. Quality work groups within the department evaluate and make recommendations for work issues.

Anti-Fraud

Ongoing training exists across major functional areas regarding recognition of potential fraud and abuse situations. We regularly train our agent workforce on fraud and abuse, assist in ongoing claims education, and are active in local, regional and national committees to combat insurance fraud, abuse and overutilization.

We aggressively investigate and pursue prosecution of health care fraud, abuse and overutilization by providers of medical, chiropractic, dental care and other related services.

We also investigate and pursue prosecution of fraud by agents, company employees, provider employees, claimant fraud rings and other individuals.

Among other remedies, our Fraud Policy includes the following punitive actions: termination of employment or agent's contracts; recommendation of license revocation; administrative discipline; recommendation of criminal prosecution, civil litigation and restitution.

Sincerely,



Benjamin Phipps CLU, FALU, FLMI
Compliance Administrator

NATIONAL HEALTH INSURANCE COMPANY



June 27, 1994

CERTIFIED MAIL

Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

RECEIVED

JUL 01 1994

RE: Cost Management Plan

MONTANA HEALTH CARE AUTHORITY

To Whom It May Concern:

Please find enclosed our "cost management plan" as required by Senate Bill 285. We apologize for the delay in providing this report. However, the required information is quite extensive.

Please contact me at the telephone number listed below if I can be of any additional assistance in this matter.

Sincerely,

Eva A. Green, FLMI
Vice President / Compliance Dept.
(817) 640-1900 (Ext. 410)

Encl.

National Health Insurance Company

Montana Cost Management Plan

Alternative Mechanisms for Payment to Providers

22. Risk sharing by the policyholder with the Company is effected by the use of relatively high deductible and co-insurance amounts. Currently, our lowest deductible amount is \$1,000 and the co-insurance level is 50%. However, a policyholder who needs hospital services has the option of electing to use one of National Health's network hospitals. By doing so, any discount received from the hospital is applied first to the insured's out-of-pocket expenses (excluding non-covered items). Then, any remaining discount is retained by National Health to reduce claim expenses.
"Unbundling" software has been purchased and we hope to have it operational either late this year or very early in 1995.
23. Deductibles and co-insurance are also used for professional services. Payments are based on Usual and Customary Charges. Our data is provided by Medical Data Research using the 80th percentile.
24. Deductibles and co-insurance are also used for outpatient hospital services. Emergency room services are not covered unless the patient is admitted to the hospital.
25. Our Association Group insureds have the benefit of being able to purchase prescription drugs at wholesale prices through their membership in the United Service Association for Health Care. Also through this membership, discounts are available in a wide variety of areas including such items as hearing aids, glasses, and vitamins.
26. We have recently contracted with several Physician networks, all of which most probably utilize payment mechanisms that encourage the quality improvement capacities of providers.
27. Our Claims Department personnel often contact non-network hospitals to request discounts, and very often these requests are granted.

Administrative Methods

33. Our Claims Department accepts standardized claim forms.
34. Our claims system utilizes provider identification numbers (federal ID numbers). We have not yet made any changes towards standardized EOB or remittance forms. System edits to validate procedures in relation to the diagnosis code are used on a very limited basis.
35. Common coding schemes are utilized in our claims processing systems and procedures.
36. We have not yet made any investigation into electronic standardized formats for claims processing. However, we certainly will do so when use of these tools becomes more widespread.

37. Administrative costs for the entire organization are reviewed monthly. Customer responsiveness is measured by conducting surveys, monitoring telephone calls, and measuring response times. Last year, we implemented a new claims processing system which has enabled us to process claims in ten calendar days or less. In addition, this new system drastically reduced our data processing costs for claims. With regard to accuracy, two of our claims examiners have the responsibility for auditing one out of every twenty-five claims processed.
38. We are currently working to convert our main data processing system to a new vendor. This change, which includes an "Imaging" system as part of the package, is anticipated to reduce costs, provide greater flexibility, and therefore will result in further improvements to our customer service functions.

Integrated Systems for Health Care Delivery

1. Users of our Physicians Network enter the system through their chosen Network Physician. Preventive services such as Well Child Care and Mammography are included in our insurance contracts as required in many states. Specifically, Mammography is included in the coverage for Montana residents.
2. Educational materials are distributed to our Association Group insureds through their membership in the United Service Association for Health Care. There are also preventive health programs available through the membership.
3. An insured who requires hospital services may choose either a network hospital or a non-network hospital. Coverage is provided under our contracts for Home Health Care, Extended Care Facilities, and Hospice Care. We encourage the use of these treatment options by eliminating the deductible and co-insurance requirements for these benefits.
- 4.and 5. National Health has recently signed contracts in most of the states with physician networks such as Beech Street, Capp Care, and others. Unfortunately, we have not yet been able to identify an appropriate provider network in Montana. We have contracted only with the highest quality provider systems available in a state. Therefore, quality issues are an integral part of these networks' programs. Regarding cost, our implementation of these contracts will allow us to receive discounts on all professional services rendered as well as some ancillary services. The projected savings, based on data obtained from past claim payments, are large enough that we have been able to give to our existing insureds a \$15 copayment physician's visit benefit for no extra premium charge.

Our Association Group insureds are able to purchase prescription drugs through a wholesale distributor as a benefit of their United Service Association for Health Care membership. Discounts on various other medical items are also available.

Our definition of "Physician" in our contracts is sufficiently broad to include any provider whose licensure allows the provision of the particular treatment.

6. We are constantly searching for ways to improve in the areas of cost containment, access, reduction of administrative burden, and continuous quality improvement. We are normally always working on the implementation of various improvements to our systems and organization.

Third Party Liability/Coordination of Benefits

28.-32. Third Party Liability is pursued when our personnel are aware of the existence of such a situation. However, Coordination of Benefits is an area in our claims processing system that needs to be reviewed and improved. Hopefully, we will be able to address this issue during 1995.

Utilization Management

12. Case Management is performed by our reinsurer on selected catastrophic or chronic claims.

13. Pre-admission review is not required by our contracts.

14.-21. We have not yet implemented Utilization Review techniques in our normal claims processing. In the past, we have had some hospital bill auditing programs in place but these were discontinued because they were not cost effective. We expect in the near future to begin exploring the services of various vendors who provide Utilization Review services. Hopefully, we will begin implementing some basic programs in 1995.

Quality Improvement and Assessment

7.-10. Our contracts with various physician networks are with organizations that have quality assessment and evaluative functions in place.

Anti-Fraud

39.-41. Our anti-fraud efforts in the past have relied on the experience and alertness of our claims staff. Two states have already passed requirements that an anti-fraud unit be in existence for an insurer. Therefore, we will soon be establishing such a unit and placing more emphasis on its function. Also, several states are requiring fraud warnings to appear on applications, policies, and claim forms.

March 24, 1994

Ms. Dorothy Bradley
Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

Re: Cost Management Plans

Dear Ms. Bradley:

As requested, itemized below in the order presented, are the responses to your request for Cost Management information.

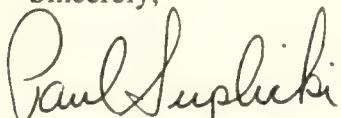
- Areas One, Two and Three are outlined in Attachments #1 and #2.
- Areas Four, Five, Six and Seven are outlined in Attachment #3.

Our Financial Analysis area discussed the completion of the "Health Insurer Data Sheet" with Mr. Steve Yeakel and it was decided that all we need to submit is the following information for calendar year 1992:

Contracts - 18
Covered Lives - 96

I trust the above information is satisfactory.

Sincerely,



Paul Suplicki
Contract Consultant
Group Contracts & Compliance Division

PS:pf

I. Introduction

We are pleased to announce our enhanced Utilization Review and Case Management product, available to all non-PPO NYL Comprehensive Major Medical clients on January 1, 1993. Utilization Review and Case Management, is the first product of the new Managed Indemnity product portfolio. Additional products, to be introduced in the future, include Outpatient Precertification, High Risk Maternity Management and Centers of Excellence.

The new Utilization Review and Case Management product will be supported by ETHIX and by Preferred Health Care. This replaces the current PAUR and Case Management programs administered by CoMed. ETHIX is one of the top companies in utilization management today. An overview of ETHIX's capabilities was provided in the ETHIX/CoMed merger Field Release, dated October 12, 1992, and are described further in this release. Preferred Health Care is one of the top specialty mental health management companies. Their capabilities are described in the Managed Mental Health Field Release dated October 26, 1992.

Utilization Review continues to play an important role for non-PPO clients. It is through utilization management that excessive or unnecessary health care costs are identified and controlled. Our new Utilization Review program is designed to control inpatient confinements, making sure that proper authorization for services and medical treatment is obtained, monitoring the length of the stay and helping to ensure that the care the patient is receiving is appropriate.

The new Case Management program is designed to monitor and control the treatment, care and expenses associated with catastrophic illnesses and medical conditions. The medical care (both inpatient and outpatient) for catastrophic illnesses are usually high-dollar items which can have a devastating effect on claims experience. The costs of these procedures are rising at an alarming rate. Our Case Management program helps to control these costs while helping to ensure that patients receive quality care in the most appropriate setting.

As supported by ETHIX and Preferred Health Care, the Utilization Review and Case Management programs offer a variety of attractive features for the insured, employer and New York Life including:

- Integration
- Cost containment
- Continuity of service to the patient

II. Product Highlights

A. Product

The new Utilization Review and Case Management product consists of six components. These are:

1. Admission Certification
2. Continued Stay Review
3. Discharge Planning Review
4. Patient Advisory Services
5. Case Management
6. Specialized Mental Health Review

The first four components are grouped together as our basic Utilization Review program, and cannot be selected individually. The fifth component, Case Management, is automatically included in all of our major medical policies. The sixth component, Specialized Mental Health Review, is provided through the recently released Managed Mental Health Indemnity product, and is available only to policyholders who elect that product.

See Attachment I for an expanded discussion of each of these components.

The first five components are supported by ETHIX. The sixth component is supported by ETHIX for intake and triage, and by Preferred Health Care for all review and management functions.

B. Vendors

ETHIX Care Management, the subsidiary of ETHIX that supports non-PPO programs, has provided Preadmission Certification, Concurrent Utilization Review, Case Management and Maternity Review since June, 1986, and Pre-Treatment Authorization of Selected Surgical and Diagnostic Procedures and Ambulatory Care Utilization Review since June, 1989. High Risk Maternity Management has been provided since August, 1991.

Overall, ETHIX managed 108,000 hospital admissions in 1991 and maintained an average length of stay of 4.7 days. Currently, ETHIX has over 400 employees located in 18 offices nationwide.

As a result of its tremendous growth, ETHIX Corporation was recognized by "Inc." magazine in December, 1991, as ranking 135th out of the top 500 fastest growing privately held companies. In addition, ETHIX was identified by Blue Cross/Blue Shield Association as one of the top 10 to 15 utilization management companies because of its reputation and its perception in the market place.

Preferred Health Care's managed mental health programs have enabled their corporate clients throughout the country to realize substantial savings in mental health costs while enhancing access to appropriate treatment. PHC was the first organization to offer a fully integrated managed mental health care program and has unique experience in the development and delivery of comprehensive mental health care benefit management systems. PHC's managed care programs are provided to beneficiaries of such organizations as GTE, General Motors/UAW, Chrysler Motors/UAW, the General Electric Lighting Division.

PHC is headquartered in Wilton, Connecticut and operates five regional offices located in Detroit, Dallas, Orange County California, Tampa and Chicago. The total number of employees of PHC is over 700 including 240 full-time mental health clinicians serving over 7 million covered lives in their managed mental health products.

C. New Certificate Booklet Language

Certificate Booklet Language has been updated to reflect our current administrative practices, meet state filing requirements and accommodate new and future products.

A sample of the updated Utilization Review Language is included in Attachment II.

III. Implementation

A. New Cases

Effective January 1, 1993, our standard benefit will include the new Utilization Review and Case Management product, with the exception of proposals that have been released or are in the process of being released.

B. Existing Cases

Existing policyholders with PAUR may opt for the new Utilization Review and Case Management product at any time, including at renewal. Group Representatives should strongly encourage clients to opt for the new product in conjunction with any other benefit change in plan, but should discourage any change in plan solely to implement this product because of the time and expense involved in producing new Certificate Booklets for a large number of clients.

For existing policyholders who do not elect the new product there will be no effect on the current PAUR requirements.

IV. Underwriting and Pricing

A. Eligibility Requirements

The new Utilization Review and Case Management product does not have any underwriting requirements that are different from the existing PAUR product. All prospective cases and inforce comprehensive major medical business that meet current eligibility rules may elect or be offered the new products. This includes all types of funding methods.

B. Rate Adjustments

The effect on current rates will be addressed by Underwriting under separate cover and presented at the November Zone Meetings.

C. Fees

Policyholders will be charged a per employee per month fee for the utilization review component of the new Utilization Review and Case Management product. This replaces the old mechanism of charging on a per review basis and is more consistent with the practices of the competition. Case Management will continue to be paid on an hourly basis for each case, with the charges being applied to the policyholder's experience.

The Utilization Review and Case Management fee calculations will be included under separate cover with the complete underwriting package. Depending on which system a particular case is billed on these fees will either be part of the billed premium or listed as a separate fee.

A Utilization Review fee will be paid to ETHIX on a per employee/per month basis for policyholders that have the new Utilization Review and Case Management product, and an additional fee will be paid to Preferred Health Care for those policyholders that have the managed mental health component.

V. Communications

A. Brochures

There will be a marketing brochure for the Managed Indemnity product portfolio which will be distributed at the Zone Meetings. This will be a single integrated brochure covering Utilization Review and Case Management, including the Specialized Mental Health Review. The brochure will be modified to include Outpatient Precertification, High Risk Maternity Management and Centers of Excellence when those additional products become available.

Attachment I

Introduction

In order to provide our clients with the comprehensive managed care programs that are essential in today's economy and medical care environment, New York Life has carefully designed Utilization Management programs. The goals of these programs are:

1. To promote quality, cost effective health care that is medically necessary, appropriate in setting and appropriate for diagnosis.
2. To promote the use of quality, cost effective services among employers, employees and providers and to increase awareness of the benefits of alternatives to inpatient care and treatment, such as pre-admission testing, outpatient surgery and home health care.
3. To increase employee awareness of health care costs and management by encouraging employees to be active participants in their health care choices.
4. To assist employers in their efforts to spend benefit dollars cost-effectively.
5. To assist patients in identifying treatment alternatives for catastrophic illnesses or injuries.

It is our philosophy to work as the advocate of clients and their employees as they participate in the health care delivery system. We firmly believe that managing health care costs must be a coordinated effort. Health care providers are an important part of this process, as are employees who use health care services and employers who pay for health care benefits.

Utilization Review

1. Admission Certification

Non-emergency Admission Review - When a physician determines that an insured employee or dependent requires inpatient care, preadmission certification must be obtained by calling the New York Life utilization review program's dedicated toll-free number, at ETHIX. Utilization review works best for the patient when requests for preadmission certification are made no later than seven working days in advance of admission. While anyone may notify ETHIX, it is the insured employee's responsibility to ensure it is done. Consequently, if New York Life does

Employee communications are being handled via a Quick Claims Kit insert.

B. Proposal Pages

We will be providing new standard proposal pages that will replace any previous materials used to illustrate the current Prior Authorization Utilization Review (PAUR) product.

additional days as medically necessary based on the information provided by the patient's physician.

2. Continued Stay Review

If the patient's medical condition requires inpatient care beyond what was originally planned, additional days may be authorized by ETHIX as information supporting the need for continued inpatient care is provided by the patient's doctor. This step occurs automatically. ETHIX assumes responsibility for monitoring the patient's progress with the objective being the avoidance of unnecessarily long stays. All admissions are monitored in this way on a concurrent basis.

The nurse usually performs concurrent review on the first working day prior to the expiration of authorized days or every third day of the patient's hospital stay, whichever comes first. Additional reviews are scheduled based on the patient's medical status and continuing treatment plan. ETHIX will monitor patients more frequently - daily, if necessary - to review the medical necessity and appropriateness of each hospital day.

If the need for hospitalization is not confirmed the same procedure previously described for non-certification of a planned admission will be used.

3. Discharge Planning Review

In order to facilitate early discharge, for patients who still require some medical care, but not the intensity of services required in an inpatient setting, ETHIX will work with the patient, the patient's doctor, and the facility on a discharge plan. When ETHIX determines that discharge planning is indicated and the physician has written the appropriate orders, ETHIX will contact an appropriate health care agency. If indicated, the health care agency (such as nursing home, home health care, intravenous medication therapy specialists, hospice, etc.) may complete an on-site evaluation of the patient in order to determine the most appropriate care plan. This evaluation will be completed after consultation with the patient, attending physician, and hospital staff. Together they will develop a plan to implement home health care or other alternatives in lieu of continued confinement. This plan will be communicated by the home health care agency to ETHIX by telephone for certification. A written notice as well as telephone notification of what has been certified will be sent to the agency providing the service.

The ETHIX nurse reviewer will monitor the care being provided and assess the need for continued care and/or services for up to 30 days post-

not receive written notification, from ETHIX, that the pre-certification process was initiated, the claim for that stay will have a benefit penalty applied to it.

Each admission is evaluated by a registered nurse. If the need for admission is established (i.e., the diagnosis and proposed treatment plan meet the criteria for inpatient treatment) the nurse then authorizes the admission and assigns an initial length of stay using the 10th percentile of the national norms as determined by the Professional Activity Study (PAS) of the Commission on Professional and Hospital Activities (CPHA) as a guide.

ETHIX confirms its authorization in writing to the patient, doctor and hospital, and information is also sent to the servicing New York Life claims office. If this written authorization is not expected to arrive prior to admission, ETHIX will notify the patient's doctor and admitting hospital of its authorization by telephone. The preadmission certification is valid for 90 days from the date issued.

If the nurse believes the patient can be treated effectively as an outpatient, ETHIX suggests alternative care consistent with the patient's needs. For example, preadmission testing is encouraged. ETHIX may also recommend same-day surgery or other alternative care.

If the nurse is unable to certify a planned admission (or a part thereof, e.g., preoperative day), or an emergency admission, a physician evaluator is contacted to discuss the case. ETHIX has three on-site medical directors at the corporate office and over 100 physicians who participate as physician evaluators. Over 85% of these physicians are board certified in their respective specialties. Nearly all of the medical specialties are covered by these participating physicians.

If the physician evaluator is unable to certify the case based on the information the nurse has obtained, the patient's doctor will be contacted to discuss the case. Once the patient's doctor is contacted, he/she will be given the opportunity to explain the patient's need for admission with the intent of developing a treatment plan which is acceptable to the patient's doctor and ETHIX. If the physician evaluator agrees with the new information and treatment plan, the admission is authorized.

If the physician evaluator and attending physician are unable to reach agreement on the need for admission, ETHIX will not recommend the case for certification. The patient's family and doctor are notified of ETHIX's recommendation by telephone. Written notice is sent to the patient's family by registered mail with copies to the doctor, and to New York Life. Days

that are not medically necessary may be denied for benefits by New York Life if supported by appropriate Certificate Booklet language.

The attending physician or the family member may appeal a utilization review determination within 30 days. Written notification of the appeal decision will be provided within 60 working days after the receipt of the appeal. An expedited appeal is available, as necessary.

Emergency Admission Review - ETHIX must be contacted within 48 hours or two business days following an emergency admission (the term "emergency treatment" means a sudden unexpected onset of a medical condition which, in the absence of immediate medical care, could reasonably result in placing the patient's life or the lives of others in jeopardy or causing serious impairment to the patient's bodily functions). This notification enables ETHIX to establish the medical necessity and appropriateness of the patient's admission and to ensure that the patient's initial course of treatment is being efficiently managed.

If the need for admission is confirmed (i.e., the diagnosis and treatment plan meet the criteria for inpatient treatment), then the nurse authorizes the admission and assigns an initial length of stay using the 10th percentile PAS as a guide. ETHIX confirms its authorization of the emergency admission to the patient, doctor, facility and to New York Life. Again, if proper notification does not occur, New York Life will apply a benefit penalty.

If the need for admission is not confirmed the same procedure previously described for non-certification of a planned admission will be used.

Maternity Review - New York Life recommends insured mothers-to-be call ETHIX at the toll-free number as soon as pregnancy has been medically confirmed. At that time, the patient can "pre-register" for certification, as well as receive an assessment to determine if she is at risk for complications during her pregnancy or at risk of experiencing premature birth. If the patient is felt to be at high risk for either situation, the patient's case will be referred to the appropriate individuals to be considered for case management services. As soon as ETHIX is notified of the confirmed pregnancy, the precertification process is completed. The notification to initiate the process can come from the covered employee, patient, doctor, or hospital, but is not limited to these sources. ETHIX will confirm the precertification by written notification to the covered employee/patient, doctor, facility, and to the servicing New York Life claims office within two working days of receiving the appropriate information necessary to complete the certification. An initial length of stay is assigned using national norms and accepted clinical practice norms for a normal delivery or a C-section delivery. ETHIX will concurrently monitor and certify any

hospitalization, or according to the provisions of the covered employer's health benefit program.

The patient or the patient's family are always able to select a health care agency other than the agency recommended by ETHIX. Discharge planning alternatives are certified in accordance with the employer's health benefit program.

4. Patient Advisory Services

Patient Advisory Services are available through the same toll-free telephone number. This is a patient advocacy program supported by utilization review nurses specially trained to respond to employees' health care questions. Through the Patient Advisory Service, a staff of registered nurses are available by telephone to respond to employee questions about on all aspect of the Utilization Review and case management process and other pertinent information on the health care delivery system.

The patient advisory nurses are available to provide employees and their families with pertinent, accurate information on health related topics and health care resources available in their community.

5. Case Management

The primary emphasis of the New York Life/ETHIX Case Management Program is to identify quality, cost-effective health care alternatives for individuals experiencing catastrophic illness or injuries. Avoiding long-term hospitalization in acute care facilities, ensuring patients receive care at the appropriate level and in the appropriate setting, and that the care and treatment are delivered in a cost-effective manner by accountable health care providers, best defines the program's goals.

The first notification of a potential large or catastrophic claim often originates from the ETHIX clinical review staff via the utilization review process. As insured employees or health care providers call ETHIX to obtain "certification" for scheduled or emergency health care services as required by the group health benefit plan, the registered nurses and physician advisors providing clinical review and patient assistance are alert for situations which may benefit from proactive involvement by a case manager. Aided by a sophisticated utilization management software program that "flags" a target list of diagnoses and identifies patterns such as repeat hospitalizations, the utilization management staff will identify cases and refer them to the case management program.

The claims examiner, employer, medical providers and patients themselves are also important sources of referrals. ETHIX and New York Life work to educate and encourage these groups to provide appropriate case referrals at the earliest possible time.

All referrals are carefully evaluated to determine the appropriateness of case management intervention, to ensure that the fees for case management services are used wisely.

New York Life's Claims operation and ETHIX work together in an integrated process to approve cases for review, to review benefit exception requests for alternative care, and on the various administrative aspects of the program.

A patient meeting one or more of the diagnoses or patient care situations identified below is referred for case management:

- o Ongoing hospitalizations where the length of stay is greater than 14 days;
- o Rehabilitation hospital admissions
- o Respirator dependent patients
- o Patients requiring Total Parenteral Nutrition (TPN)
- o Chronic dialysis cases
- o Post-operative transplants
- o Multiple injuries from Motor Vehicle Accidents (MVA) or trauma
- o Progressive neuromuscular disorders
- o Second or third degree burns - 30% or more of the body area
- o Repeat admissions for the same or similar diagnoses
- o Cancer requiring radiation and/or chemotherapy
- o Strokes with residual paralysis
- o Hip fractures
- o Spinal cord injuries
- o Premature infants
- o AIDS cases and/or Immunodeficiency diseases
- o Patients where nursing home placement, at-home nursing care, extensive durable medical equipment or transfer to a rehabilitation facility is anticipated upon discharge

The Case Management Process:

1. A referral is reviewed by the case manager to assess for opportunities for facilitation of positive outcomes through the case management program.
2. Authorization for initiation of case management is obtained from New York Life by ETHIX. NYL assesses the status of the patient and checks for group eligibility.
3. "Introduction to Case Management" letters are mailed to the insured employee/patient and attending physician, and a "Release of Medical Information and Case Management Authorization" letter is sent to the insured employee or patient.
4. An "Authorization for Case Management" letter is sent to New York Life by ETHIX confirming approval of case management services.
5. Telephone contact with insured employee/patient and attending physician is initiated.
6. As indicated and if appropriate for the case, the case manager will assign an appropriate health professional to do an on-site assessment to ascertain specific patient needs.
7. A thorough review of the patient's medical history, current diagnosis and treatment plan, projected health care needs and cost, potential alternatives to current or future treatment plan, and socioeconomic, cultural, or environmental factors which will influence the patient's recovery, stabilization or treatment setting is performed. Pertinent information is communicated by telephone to New York Life upon completion of the initial evaluation, as indicated by the needs of the case. A written initial report is then mailed to New York Life within 10 days. New York Life reviews each recommendation and suggested alternative prior to its implementation, and informs ETHIX as to whether or not those alternatives can be considered as covered under the health benefit plan. If such plan includes suggested treatment that is not covered by the health benefit plan, New York Life in collaboration with other appropriate parties grants approval or declines to treat those charges as covered payments under the health benefit plan.
8. On an ongoing basis, the case manager monitors and evaluates effectiveness, medical necessity, dependability and patient/family satisfaction with all ancillary health care providers involved with patient care or equipment provided. In addition, case management identifies interventions and makes recommendations which outline the opportunities

to facilitate quality care in a cost-efficient manner and recommends retaining the case in management or closing as indicated. Written status updates are provided to New York Life every two weeks unless activity warrants a less frequent or more frequent pattern.

6. Specialized Mental Health Review

The mental health component of utilization review requires highly specialized expertise, and a special understanding and sensitivity to the unique issues associated with mental illness and chemical dependency. For that reason, the mental health portion of the New York Life utilization review program is managed by Preferred Health Care (PHC), one of the country's premier managed mental health specialty vendors.

The program is fully integrated into the overall New York Life utilization review program, and is therefore easy for insureds to use. For example, all phone calls, whether for mental health or for medical/surgical conditions are made to a single 800#, at ETHIX. New York Life, ETHIX and Preferred Health Care have put in place internal workflow procedures so that mental health cases are managed by Preferred Health Care. This combines the best of both worlds - an integrated program, with managed mental health performed by a top specialty vendor.

This program is described in detail in the Managed Mental Health field release dated October 26, 1992.

Attachment II

Sample Certificate Booklet Wording

"UTILIZATION REVIEW" means New York Life's utilization review program described below. The Utilization Review process determines if the services described below are Medically Necessary under this coverage.

This determination is not medical advice. All treatment decisions are the responsibility of the patient and the attending doctor.

NOTICE REQUIREMENTS

UTILIZATION REVIEW is required for the following services:

All Inpatient Confinements including Maternity

Who initiates Utilization Review?

The Family Member or their designated representative must initiate **UTILIZATION REVIEW**.

To initiate **UTILIZATION REVIEW**, call the telephone number listed on your Medical Identification Card.

When to call for Utilization Review

Inpatient Confinement

For an **INPATIENT CONFINEMENT**, a telephone call for **UTILIZATION REVIEW** must be made at least 7 days, or as soon as reasonably possible, prior to the start of the Confinement, except in the event of a confinement due to a **MEDICAL EMERGENCY**.

For an **INPATIENT CONFINEMENT** due to a **MEDICAL EMERGENCY**, a telephone call for **UTILIZATION REVIEW** must be made within 2 working days after the start of the confinement, or as soon as reasonably possible thereafter, as determined by New York Life.

"Working Days" means Monday to Friday, inclusive; but will not include any day which falls on the following: New Year's Day, President's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day.

Maternity Care

For Maternity Care, we recommend that the Family Member calls for UTILIZATION REVIEW as soon as they know of the pregnancy, but the Family Member must call for UTILIZATION REVIEW prior to the start of the fourth month of such pregnancy.

UTILIZATION REVIEW DETERMINATIONS

For non-emergency care, an initial UTILIZATION REVIEW determination will be made within 3 working days after receiving the information necessary to make the determination. Written notification of such a UTILIZATION REVIEW determination will be sent to the attending Doctor, Covered Facility and Family Member. For an INPATIENT CONFINEMENT due to a MEDICAL EMERGENCY, the attending Doctor and Covered Facility will be notified of the UTILIZATION REVIEW determination.

UTILIZATION REVIEW will be conducted throughout the period of INPATIENT CONFINEMENT. The attending Doctor and Covered Facility will be notified in the event of an adverse determination.

Please note: If the attending Doctor or Covered Facility fails to notify you of the determination, you may receive notice of an adverse determination after the services have been rendered.

APPEALS PROCESS

The attending Doctor or the family member may appeal a UTILIZATION REVIEW determination within 30 days of the determination. To appeal, call the telephone number on your Medical Identification Card. Written notification of the appeal decision will be provided within 60 working days after receipt of the appeal. An expedited appeal is available, if necessary.

EFFECT OF UTILIZATION REVIEW ON BENEFITS

IMPORTANT This determination is not a guarantee of benefits. The final decision as to the benefits a family member qualifies for will be made by New York Life upon submission of a claim. Payment of benefits is subject to the patient's eligibility on the date the service is rendered and any other contractual provisions of the policy.

UTILIZATION REVIEW may be performed by an organization named by New York Life. Any decision made by such organization shall be treated by New York Life as advisory only.

It is the responsibility of the Family Member or their designated representative to call for UTILIZATION REVIEW. Failure to call for UTILIZATION REVIEW will result in a reduction in benefits, as follows:

For Inpatient Confinements, an additional deductible of \$500 will apply to each period of confinement.

These deductibles will apply in addition to any other deductible in the policy.

Any penalty amount for not complying with the Utilization Review program will not be used to satisfy any Deductible or out-of-pocket limit under the policy.

Details

I. Introduction

Our new Outpatient Utilization Review program is designed to control outpatient services by making sure that proper authorization for services and medical treatment is obtained, monitoring the length of the treatment and helping to ensure that the care the patient is receiving is appropriate. The Outpatient Utilization Review Program is fully integrated with the other Managed Indemnity products and services: inpatient utilization review, case management, and the indemnity discount program.

II. Product Description

The new Outpatient Utilization Review product consists of four components. These are:

1. Elective Surgery Review (Surgery not performed in a doctors office*)
2. Home Health Care Review
3. Speech Therapy Review
4. Physical Therapy Review

These components are grouped together as our basic Outpatient Utilization Review program, and cannot be selected individually.

Groups that elect the Outpatient Utilization Review product will automatically receive the advantages of the Indemnity Discount Programs (see Field Release 10/18/93) for all outpatient surgery and treatment provided by a contracted vendor. In addition, Fee Negotiation Services will be available for all outpatient surgery claims in excess of \$5000.

- * ETHIX will review all elective surgery when a facility charge will be billed. Generally, minor surgery performed in a doctors office such as removal of a mole, or a biopsy will not require precertification.

The details of the Outpatient Utilization Review product are as follows:

Initiating Outpatient Review

Outpatient Utilization Review must be initiated by calling the New York Life utilization review program's dedicated toll-free number at ETHIX. This call must be made at least seven working days prior to receiving treatment, or as soon as the treatment is scheduled. While anyone may notify ETHIX, it is the insured

employee's responsibility to ensure it is done. Consequently, if New York Life does not receive notification from ETHIX that the outpatient review was initiated, the claim for that treatment or service will have a benefit penalty applied to it. Covered expenses will be paid at 50% for failure to notify ETHIX of a planned outpatient surgery or treatment. This penalty is different from the standard \$500 non-compliance penalty for inpatient medical/surgical utilization review. The percentage based penalty is customary for outpatient procedures and treatment because these services are often relatively low cost. Therefore, any group that elects Outpatient Utilization Review will have two separate penalties, a 50% reduction in covered expenses non compliance penalty for out patient surgery and treatment, and a \$500 non compliance penalty for inpatient admissions.

Review Process

Each treatment or procedure is evaluated by a Registered Nurse according to established protocols. If the need for treatment is established (i.e., the diagnosis and proposed treatment plan meet the criteria), the nurse then authorizes the treatment or procedure.

ETHIX confirms its authorization in writing to the patient, doctor, treatment facility and the servicing New York Life claims office. If this written authorization is not expected to arrive prior to the start of treatment, ETHIX will notify the patient's doctor and treatment facility of its authorization by telephone. The certification is valid for 90 days from the date issued.

If the nurse is unable to certify a planned treatment or procedure (or part thereof, e.g., six physical therapy sessions versus nine requested), a physician evaluator is contacted to discuss the case.

If the physician evaluator is unable to certify the care based on the information the nurse has obtained, the patient's doctor is contacted and given the opportunity to explain the patient's need for care. The physician evaluator will attempt to work with the patient's doctor to develop a treatment plan that is acceptable to both the patient's doctor and ETHIX. If the physician evaluator agrees with the new information and treatment plan, the treatment or procedure is authorized.

If the physician evaluator and attending physician are unable to reach agreement on a treatment plan, ETHIX will not recommend the case for certification. The patient and doctor are notified of ETHIX's recommendation by telephone. Written notice is sent to the patient by registered mail with copies to the doctor and New York Life. Care that is not medically necessary may be denied for benefits by New York Life if supported by appropriate Certificate Booklet language. (See Attachment I for sample Certificate Booklet wording.)

Appeals

The attending physician or the family member may appeal an outpatient utilization review determination within 30 days. Written notification of the appeal decision will be provided within 60 working days after the receipt of the appeal. An expedited appeal is available, as necessary.

III. Vendor

The Outpatient Utilization Review product will be supported by ETHIX National, formerly ETHIX Care Management. ETHIX National, the subsidiary of ETHIX that supports our Utilization Review product for all of our managed indemnity cases, is a nationwide utilization management and case management company that serves over 3700 employers and performs utilization management for over 2 million individuals.

ETHIX has three on-site medical directors at the corporate office and over 100 physicians who participate as physician evaluators. Over 85% of these physicians are board certified in their respective specialties. Nearly all of the medical specialties are covered by these participating physicians.

As a result of the merger of CoMed into ETHIX in October, 1992, New York Life maintains an ownership position in the ETHIX Corporation.

IV. Availability

The Outpatient Utilization Review product filing has been approved for sale in all states except New Jersey and Pennsylvania. Outpatient Utilization Review may not be sold for insured cases situated in either of these states until filing approval has been received.

V. Implementation Schedule

New Cases

Effective January 1, 1994, Outpatient Utilization Review is available for all new Managed Indemnity groups that have the Inpatient Utilization Review product introduced last year. Outpatient Utilization Review cannot be added to indemnity cases with PAUR because the PAUR product does not contain the variable language necessary for filing approval.

Existing Cases

Existing policyholders with new Inpatient Utilization Review may opt for Outpatient Utilization Review at any time, including at renewal.

VI. Underwriting and Pricing

Underwriting Requirements

No new underwriting requirements have been established for the new Outpatient Utilization Review product. All prospective cases and inforce cases that have the new Inpatient Utilization Review may elect or be offered the new product.

Rate Adjustments

The Outpatient Utilization Review rate credit is as follows:

- a) groups with a deductible of \$1000 or less: 0.50%
- b) groups with a deductible of \$1000 or more: 0.25%

Fees

Policyholders will be charged a capitated fee for the Outpatient Utilization product as follows:

1Q94	2Q94	3Q94	4Q94	1Q95
\$.42	\$.43	\$.44	\$.45	\$.46

Depending on which billing system is used for a particular case, these fees will be billed either as part of the premiums or as a separate fee.

VII. Communications

Brochures

A marketing slip sheet for Outpatient Utilization Review is available to be used with the Managed Indemnity product brochure. These slip sheets can be ordered through Moore Warehouse form # G 7208. See Attachment II.

Employee communications are being handled via a Quick Claims Kit insert.

Attachment I

Utiliation Review-includes UR for outpatient treatment

"UTILIZATION REVIEW" means New York Life's utilization review program described below. The Utilization Review process determines if the services described below are Medically Necessary under this Coverage. New York Life will pay only for services and supplies which are Medically Necessary.

A UTILIZATION REVIEW determination is not medical advice. All treatment decisions are the responsibility of the patient and the attending Doctor.

NOTICE REQUIREMENTS

UTILIZATION REVIEW is required for the following services:

Inpatient Confinement;

Maternity Care; and

Outpatient Treatment - This includes the following services done on an outpatient basis:

Elective surgery;
Home Care;
Physical Therapy;
Speech Therapy

The term "Elective surgery" means a surgical procedure that the family member has the choice of:

- (a) whether or not to have it done; and
- (b) when to have it done.

The term "Elective surgery" does not include any such procedure required in an Emergency.

Who initiates Utilization Review

The Family Member or their designated representative must initiate UTILIZATION REVIEW.

To initiate UTILIZATION REVIEW, call the telephone number listed on your Medical Identification Card.

When to call for Utilization Review

Inpatient Confinement

For an Inpatient Confinement, a telephone call for UTILIZATION REVIEW must be made at least 7 days prior to the start of the Confinement or as soon as an admission is scheduled, except in the event of a confinement due to a Medical Emergency.

For an Inpatient Confinement due to a Medical Emergency, a telephone call for UTILIZATION REVIEW must be made within 2 working days after the start of the confinement, or as soon as reasonably possible thereafter, as determined by New York Life

"Working Days" means Monday to Friday, inclusive but will not include any day which falls on the following: New Year's Day; President's Day; Memorial Day; Fourth of July; Labor Day; Thanksgiving Day; and Christmas Day.

Maternity Care

For Maternity Care, we recommend that the Family Member calls for UTILIZATION REVIEW as soon as they know of the pregnancy, but the Family Member must call for UTILIZATION REVIEW prior to the start of the fourth month of such pregnancy.

Outpatient Treatment

For Outpatient Treatment services listed under "Notice Requirements", a telephone call for UTILIZATION REVIEW must be made at least 7 days prior to the start of the treatment or as soon as the treatment is scheduled, except in the event of a MEDICAL EMERGENCY.

UTILIZATION REVIEW DETERMINATIONS

For non-emergency care, an initial UTILIZATION REVIEW determination will be made within 3 working days after receiving the information necessary to make the determination. Written notification of such a UTILIZATION REVIEW determination will be sent to the attending Doctor, Covered Facility and Family Member. For an Inpatient Confinement or Outpatient Treatment due to a Medical Emergency, the attending Doctor and Covered Facility will be notified of the UTILIZATION REVIEW determination, and written notification will be sent to the family member's home.

UTILIZATION REVIEW will be conducted throughout the period of Inpatient Confinement or the course of outpatient treatment. The attending Doctor and Covered Facility will be notified in the event of an adverse determination, and written notification of such adverse determination will be sent to the family member's home.

Please note: If the attending Doctor or the Covered Facility fails to notify you of the determination, you may receive notice of an adverse determination after the services have been rendered.

UTILIZATION REVIEW APPEAL PROCESS

The attending Doctor or the family member may appeal a UTILIZATION REVIEW determination within 30 days of the determination. To appeal, call the telephone number on your Medical Identification Card. Written notification of the appeal decision will be provided within 60 working days after receipt of the appeal. An expedited appeal is available, if necessary.

NON-NOTIFICATION PENALTY

IMPORTANT This determination is not a guarantee of benefits. Payment of benefits is subject to the patient's eligibility on the date the service is rendered and any other contractual provisions of the policy. The final decision as to the benefits a Family Member qualifies for will be made by New York Life upon submission of a claim.

UTILIZATION REVIEW may be performed by an organization named by New York Life. Any decision made by such organization shall be treated by New York Life as advisory only.

When it is the responsibility of the family member or their designated representative to call for UTILIZATION REVIEW, failure to do so will result in a reduction in benefits, as follows:

For Inpatient Confinement including Inpatient Confinement for Maternity Care, a penalty amount of \$500 will apply to each period of confinement.

For Outpatient Treatment, expenses will be paid at 50%.

Any penalty amount for not complying with the Utilization Review program will not be used to satisfy any Deductible or out-of-pocket limit under this Plan.



Outpatient Utilization Review

For employers who desire an added degree of cost containment, the New York Life Managed Indemnity Products include an optional feature called Outpatient Utilization Review. This feature is designed to control the escalating costs of outpatient procedures.

The Outpatient Utilization Review (UR) program controls costs by reviewing the need for outpatient treatment, while helping assure the patient receives appropriate care. The patient is responsible for initiating the UR process before receiving care for any of the following:

- all elective outpatient surgery
- home health care
- outpatient physical therapy
- outpatient speech therapy

It is standard practice in the industry to have a highly detailed list of diagnostic and surgical procedures that patients must consult before initiating outpatient UR. New York Life's Outpatient UR is distinguished in the industry, because our outpatient list is made up of broad categories and allows the UR agency to evaluate the need for in-depth review on a case-by-case basis. In this way, the list allows for trends in the cost and utilization of outpatient care, as well as for emerging technologies that may render a standard list obsolete.

The Outpatient UR program is similar to inpatient UR in that the patient, or the patient's representative, must initiate review for the above procedures by calling the UR agency at the toll-free number listed on the employee's identification card. The review must be initiated at least seven working days prior to the planned treatment, or as soon as the treatment is scheduled, if less than seven days in advance. To enhance the effectiveness of the program, a penalty is applied if the review process is not initiated within the required time period. To ensure that employees are aware of the program procedures, New York Life provides easy-to-understand employee communications.

Review will be continued throughout the course of outpatient treatment, and the attending Doctor or treatment facility will be notified of the UR determination.

Attachment III
Sample Proposal Page

Optional Outpatient Utilization Review

For employers who desire an added degree of cost containment, we offer an optional outpatient UR program. Designed to control the escalating costs of certain outpatient treatment and procedures, this program reviews the medical necessity for the following areas of treatment, before the patient receives care:

- all elective outpatient surgery
- home health care
- outpatient physical therapy
- outpatient speech therapy

Like inpatient UR, the patient, or the patient's representative is required to call the UR agency at least seven days prior to receiving treatment, or as soon as the treatment is scheduled. At that time, the UR agency determines the need for an in-depth review on a case-by-case basis, a practice which is atypical in the industry. By employing a broad, list of outpatient treatments and procedures, our program allows for trends in the cost and utilization of certain care, as well as for emerging technologies that may render a standard list obsolete.

AREA FOUR: Alternative Mechanisms for Payment to Providers

In order to monitor claims costs, the claims experience of group policyholders is analyzed by New York Life and trends are identified based on diagnosis and types of treatment rendered. We include several benefit provisions in our medical care (e.g. Major Medical) plans that are designed to maximize savings wherever possible.

Some of these policy provisions contain incentive benefits whereby the insured person can receive a better benefit payment by participating in Cost Containment Programs. Under several of our programs we are also able to monitor the quality of care while still providing the most cost effective insurance coverage for that care.

New York Life's Major Medical Plans (both Supplementary and Comprehensive) contain several common cost containment provisions (e.g., deductibles, coinsurance, policy maximums) related to provider payment. We are able to reduce costs by reducing benefit payments by simply applying a policy deductible.

Major Medical Plans have the potential of paying an unlimited dollar amount for covered medical expenses. In essence, almost anything that is medically necessary may be covered under such Plans. This fact can present problems such as over-utilization of medical facilities as well as an increase in insurance benefits being paid for unnecessary medical care. The method selected to solve these problems is to make the insured person responsible for a portion of the medical charges through the use of coinsurance. Most plans will typically reimburse 80% of the charge to the insured who is then responsible for the remaining 20%. Since the insured person has to pay for a portion of the medical expenses, the theory is that the use of unnecessary medical services will be limited.

Along the same lines, many of our plans contain Policy Maximums. These may be maximum dollar benefits payable on all charges within a year, within an insured person's lifetime or for a specified condition. The limits vary, depending on the plan; and can range from \$100 in a year \$1,000,000 in a lifetime.

Other cost containment strategies affecting provider payment include: Second Surgical Opinions, Pre-Admission Testing, Outpatient Surgery Benefits, Prescription Drug Plans, use Rebundling Software, Hospital Audit Review and the application of Usual & Prevailing Fees in our reimbursement process.

Under the Second Surgical Opinion Benefit, New York Life will pay for 100% of the covered charge for a second opinion to evaluate the need for surgery up to a specified dollar amount (e.g, \$100); then 80% of the charge; thereby providing a financial incentive to obtain a second opinion. The charge for a second surgical opinion is not subject to the plan's deductible.

If any of the program requirements are not met, the charge for the second surgical opinion will be paid in accordance with the normal policy provisions, including any deductible and coinsurance. However, if the proposed elective surgery was not recommended by the second physician, the insured person may also obtain a third opinion. The third physician should meet the same requirements as the second physician. The same benefit payment is then applied.

The Pre-Admission Testing Benefit (PAT) is utilized to reduce the length of hospital confinements and their associated costs by providing for the payment of outpatient testing for elective surgery. Under some Plans PAT is paid at 100% as an incentive to patients to take advantage of outpatient testing.

Another cost savings provision in New York Life policies applies to outpatient surgery, i.e., surgery performed in a short stay (less than one day) hospital unit, outpatient surgical clinic, emergency room or physician's office. The outpatient surgery provision is provided as an alternative to inpatient surgery in an attempt to reduce the overall costs associated with elective surgery. Although not a standard provision, some New York Life policies reimburse 100% of covered charges incurred in connection with outpatient surgery as an incentive for insured persons to use these alternatives to inpatient confinement.

Prescription Drug Plans, (have built in administrative and claim cost controls), are administered by several pharmaceutical Administrators which have networks of pharmacies participating in the prescription plan. Each organization has a similar operating procedure whereby benefit payments are made directly to the dispensing Pharmacist for prescription charges incurred by insured customers.

The Prescription Drug Plan Administrators regularly evaluate drug use patterns by insured customers as well as the dispensing patterns of pharmacies. Through such monitoring the Administrator checks for abnormal profiles that may indicate possible waste, abuse, or misuse. When problems are discovered, they are communicated to the attending physician for any necessary corrective action. The Administrators will also conduct periodic in-store pharmacy audits to safeguard and protect the financial integrity of their clients' drug benefit program. These audits also enable the Administrators to update their list of participating pharmacists under the program guidelines.

We utilize a special software package that is fully integrated with our claims processing system. This package has 1) the ability to rebundle bills which appear to have been artificially itemized ("unbundled") for the purpose of obtaining higher reimbursement, 2) performs a number of "logic" tests to evaluate the appropriateness of surgical, diagnostic, medical procedures and 3) flags claims that fall outside of generally accepted billing procedures.

In addition, we can identify providers with questionable billing practices, and have the ability to detect coding errors and/or improper codes, and identify cosmetic or experimental procedures.

Experienced audit experts and aggressive auditing guidelines make New York Life's Hospital Audit Program an effective money saver. The audit experts we select have proven track records for cost-effective results and quality service. Additionally, New York Life conducts an ongoing review to make sure that savings goals are achieved, and services are performed in a timely manner. All hospital bills in excess of \$5,000 are referred to an audit expert who, based upon the diagnoses, procedures, and services shown on the bill, will decide if an audit is warranted.

To help ensure that we effectively control claims costs, twice each year we examine our claims experience, inflationary trends, and the range of actual fees reported by industry and government studies. Billed charges that significantly exceed those made by the vast majority of providers in the same geographic area, will not be covered above the Usual & Prevailing (U&P) amount. These guidelines are updated periodically as appropriate.

AREA FIVE: Third Party Liability/Coordination of Benefits

New York Life exceeds industry standards for saving our customers money through Coordination of Benefits (COB), No-Fault, Right of Reimbursement Provisions and/or Subrogation where permissible by state law. Under COB we consistently achieve substantial savings, including Medicare. Our COB process is structured, methodical, and consistent. We ask a series of questions on the claim form to determine eligibility and identify possible duplicate coverage. We then verify the accuracy of those responses through contact with the service provider, the other carrier, and any employers involved.

COB or Non-Duplication of Benefits is applied when a person is covered under another group plan or group-type plan in addition to a New York Life plan. COB is a method of integrating benefits payable by both group health insurance plans so that the insured person's benefits from all sources do not exceed 100% of the allowable medical expense.

We investigate any claim that does not clearly establish primary coverage and should we discover duplicate coverage, our claim payment system will automatically flag subsequent claims to alert the examiner that COB applies. By including a COB provision in our policies we are able to create a substantial savings in claim payments that can be passed on to the policyholder in the form of lower premium rates.

AREA SIX: Administrative Methods

New York Life has simplified procedures for filing group insurance medical claims. When submitting the first claim for the year, a New York Life claim form is generally required to ensure that all information needed to accurately process the claim is available. In states where we offer PPO and EPO products, a claim form is not required but there may be situations (with any product) when the Claims Office may need to contact the insured or provider for additional information in order to accurately process the claim. This may include specific dependent information about other insurance, details regarding an accident, etc.

We have recently liberalized some of our Claim Form requirements to simplify the claim filing process for our customers:

- Any standard industry claim form, such as a HCFA 1500 or HCFA 1450 (aka UB-82) will be accepted in lieu of the New York Life claim form for Medical and/or Hospital expense claims.
- A claim form will not be required when an insured has "employee only" coverage unless there are unusual circumstances about the claim. If we need information, we will then contact the customer.
- A new claim form will generally not be requested if one was submitted for the patient during the last rolling 12 month period.
- Requests for updated COB information will generally be limited to once every 12 months rather than every 6 months.
- Claim forms will not be required for retirees covered by Medicare as long as the Medicare Explanation of Benefits is sent to the Claim Office.

We currently utilize the Claims Adjudication Report Extract System (CARES) to determine Plan Identification, Eligibility and various Benefit Components. Please refer to the attached Chart entitled "THE STRUCTURE OF CARES".

We accept various common coding schemes for medical claims processing including the Physician's Current Procedural Terminology (CPT-4), International Classification of Diseases, 9th Revision, 4th Edition, Clinical Modification, Procedure and Diagnosis Codes (ICD-9-CM) and the DSM III-R-Diagnosis and Statistical Manual III-Revised.

Under the CARES System the Member ID/Patient ID is the key that links on an insureds'/patients' claim history, accumulators, and maintenance information. The member's eligibility information is keyed to an eligibility event (this identifies the Plan and the effective date of coverage).

Cost Containment Codes are essential to monitor claim trends, provide reports to our policyholders and to evaluate claim programs. We also utilize Provider Records to:

- Supply the information necessary to issue checks and letters to providers;
- Check prices charged by a provider. The system can read the zip code in the Provider Record and then compare billing prices with U&P charges for that geographical area;
- Indicate that a provider is part of a Preferred Provider Arrangement in states where permissible;
- Alert the examiner to providers that may require investigation.

Note: The provider's Tax ID Number is the key to the Provider Record.

New York Life is committed to a timely processing of claims. We will pay benefits after we receive proof of claim but the member should promptly submit a completed claim form and any bills or receipts to the Claims Office or Third Party Administrator as appropriate.

We have set also in place an appeals process for denied claims in accordance with ERISA requirements.

New York Life supports WEDI's efforts addressing the major issues impacting the industries move towards an EDI environment, and, in particular, WEDI's and the American National Standards Institution's efforts to standardize claim formats and the transmission of records between trading parties. We are currently making the necessary system modifications to receive electronic claims in ANSI format from NEIC. Additionally, we are actively pursuing other trading partner arrangements using ANSI standards.

New York Life has in place a formal Quality Improvement Review Program (QIR) whereby we conduct internal performance monitoring — a program with the ability to quantify claims processing performance standards. The Company's objective are to:

- provide a standardized system of evaluating each examiner's performance on a routine basis and provide feedback to employees on their performance;
- provide a system of assessing each person's strengths and weaknesses and provide the means to improve each individual's skills;

- provide an accurate view of the current level of accuracy in all aspects of claims processing;
- establish an acceptable error rate - not to exceed 2% in dollar errors and 15% in accuracy rating.
- monitor the level of accuracy in claims processing on both an examiner and Claims Office level.
- provide an accurate database for reporting purposes.

AREA SEVEN: Anti-Fraud Efforts

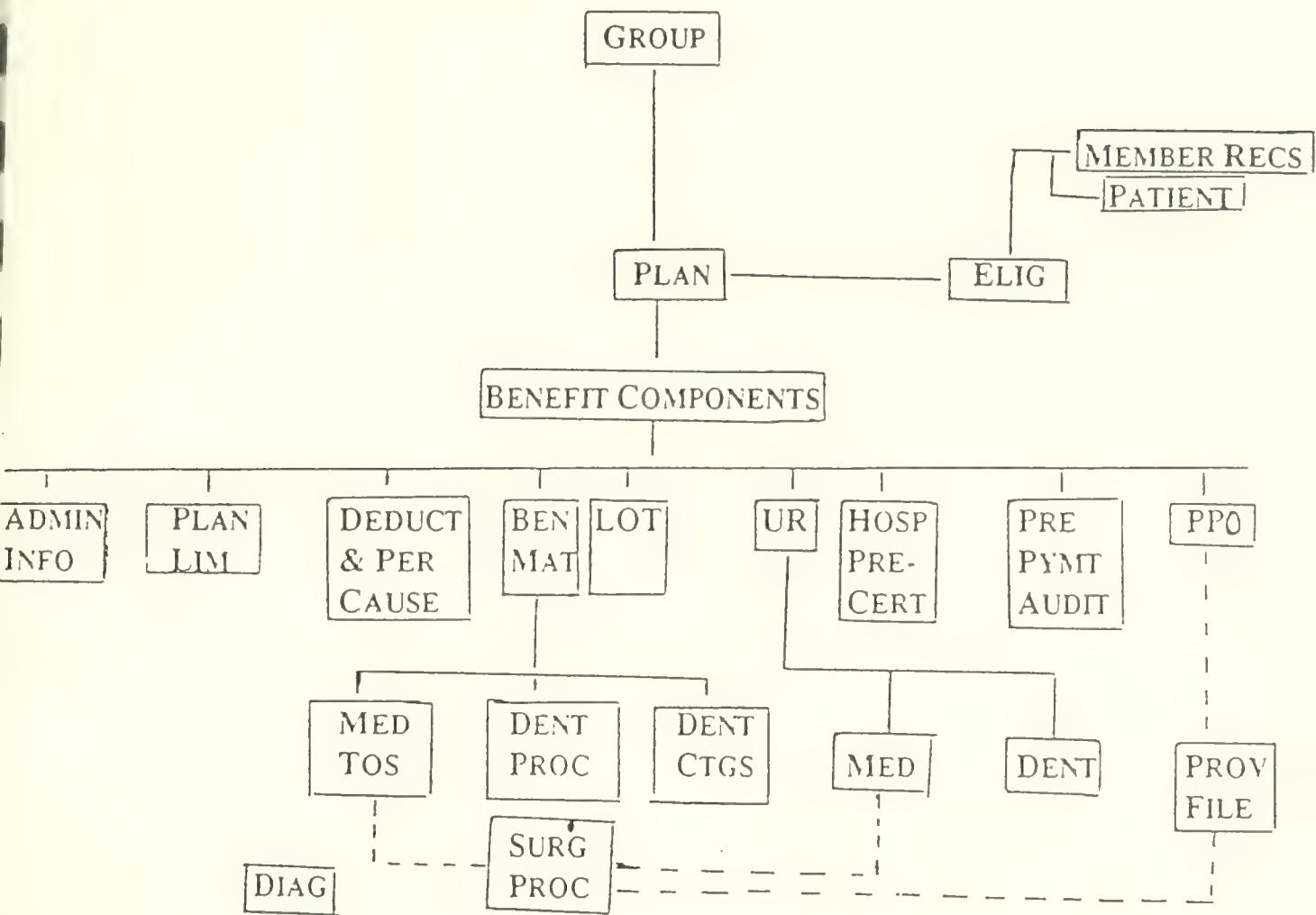
New York Life has taken major strides in the detection and prevention of fraud from all sources, resulting in one of the strongest anti-fraud platforms in the industry. With experts estimating fraudulent health care costs at approximately \$50-\$80 billion per year nationally, we've made fraud prevention a top priority.

Our efforts include creation of a multi-dimensional Fraud Prevention Program, a specialized Home Office Standards and Controls (S&C) Unit, and membership in the Board of Governors of the National Health Care Anti-Fraud Association (NHCAA)-- a consortium of leading health care insurers and other companies and agencies from the insurance and law enforcement arenas.

The key to success in fighting fraud is communication between the Home Office Standards and Controls (S&C) Unit, Claims Offices, Third Party Administrators, Agents and our Customers. The overall objective of S&C is to prevent and detect insurance fraud. Home Office activities by this Unit include:

- Identifying potentially fraudulent activity using computerized claim data, (e.g., Provider Profile and Review Program);
- Conducting timely and accurate investigations of referrals from Claims Offices, Third Party Administrators and other sources;
- Educating the Claims Office Staff on how to recognize and act upon a potentially fraudulent situation;
- Representing New York Life among industry groups primarily concerned with the topic of fraud, notably the National Health Care Anti-Fraud Association (NHCAA);
- Working with New York Life's Office of the General Counsel to help secure the prosecution of suspected claimants, providers and planholders;
- Preventing and detecting potential internal fraud (employees, marketing representatives, etc.) and prosecuting offenders. This includes ensuring the adequacy of our Claims Department's internal controls.

THE STRUCTURE OF CARES





Northwestern National Life

Employee Benefits Division

Northwestern National Life Insurance Company
20 Washington Avenue South
Minneapolis, Minnesota 55401

February 28, 1994

Montana Health Care Authority
28 N. Last Chance Gulch
P.O. Box 200901
Helena, Montana 59620-0901

VIA AIRBORNE EXPRESS

RE: Health Insurer Cost Management Plans

Northwestern National Life Insurance Company (NWNL) Employee Benefits Division (EBD) has only limited insured business in Montana with no groups situated there currently. To a certain extent, the information that we are providing is based on our national "standard". NWNL does encourage employers to consider a number of cost containment options, depending upon their location.

These programs are prioritized to a limited extent. Certain programs have more impact and importance in certain markets and less in others.

Area Seven: Anti-Fraud

NWNL is a Corporate Member of the National Health Care Anti-Fraud Association. We are a member of the Board of Governors for the NHCAA whose purpose is to improve the prevention, detection and civil and criminal prosecution of health care fraud.

NWNL is also a member and co-founder of the Midwest Insurance Fraud and Prevention Association involving insurance companies and representatives from various law enforcement agencies from Minnesota, North Dakota, South Dakota, Illinois, Wisconsin, Indiana and the Upper Peninsula of Michigan.

A copy of our Anti-Fraud Plan dated February 1994 is enclosed.

Area One: Integrated Systems for Health Care Delivery

NWNL has group policy/certificate language approved providing benefits for home health care, outpatient services, preventative (well baby) care etc. We strongly encourage insured groups to provide routine health screenings such as mammograms and pap smears, even where not mandated.

NWNL has a network of preferred providers through Private Healthcare Systems (PHCS). PHCS is a coalition of carriers who joined together to ensure a quality national network of providers in most specialties. Unfortunately, at this time, PHCS does not have a network established in Montana and does not have any immediate plans to develop one.

As part of the network, PHCS encourages the use of wellness programs and in-network services which result in lower cost to the patient; rewards efficient and thorough medical practice and allows the development of local utilization management systems to meet community needs.

Area Two: Quality Improvement and Assessment

PHCS does not have a quality assurance committee. Instead there is an ongoing quality management program. This comprehensive program integrates all components of the managed care cycle. It is designed to verify that health services are being delivered consistent with current medical practices and includes procedures for proactively working with providers to correct problems. The program measures a variety of quality components including patient satisfaction, clinical quality, cost efficiency and clinical outcomes. The quality management cycle is composed of four programs--selection, credentialing, recredentialing and quality monitoring. The cycle begins with physician selection. Selecting high quality, cost efficient providers is critical to network development. Quality physicians are identified with the help from network hospitals and through claims data. Once identified, providers proceed through the credentialing process to assure they meet a set of defined quality standards. Credentialing includes verifying the physician's license through an in-house database. In addition, PHCS has on-line access to the Federation of State Medical Boards where the physician's history is checked for any medical board disciplinary actions. Most aspects of this program are repeated annually through recredentialing. The quality monitoring program profiles physician proactive patterns and intervenes appropriately to assure quality on a continuous basis. The program uses claim data and utilization review data to assist in physician selection and monitoring.

As stated above, PHCS does not have a network of providers in Montana at this time.

Area Three: Utilization Management and Area Four: Alternative Mechanisms for Payment to Providers

Enclosed are four programs that NWNL could provide to employers in the state of Montana to promote quality improvement and cost control in relationship to healthcare costs.

The four programs that are described are:

1. Utilization Management includes reviews for medical, surgical and psychiatric/substance abuse treatment and may include the following components:
 - o precertification review;
 - o concurrent review;
 - o discharge planning and verification; and
 - o outpatient review.
2. Medical Case Management--NWNL's program is called Appropriate Care and Treatment (ACT). It promotes appropriate and high quality care for seriously injured or ill patients and helps contain costs for employers. The ACT case manager works with patients and their physicians to have the patient treated at an appropriate facility, moved to an alternative setting if appropriate and assisted by specialists when needed. **HOWEVER**, medical decisions are solely the responsibility of the patient and their treating physician.
3. Managed Prescription Drug Care--a fully integrated service is made available through PCS Inc. The system includes controls for cost, quality and safety for both maintenance drugs and acute drugs, each of which can be tailored to meet an employer's specific needs.
4. Centers of Excellence--NWNL's program is called Access to Excellence. This program for transplants and advanced procedures allow employer plans to encourage the use of specific providers of care recognized as "centers of excellence" having established experience and skills in these procedures.

Area Six: Administrative Methods

Acceptance of Standardized Claims Formats:

NWNL accepts the listed standardized claims formats: HCFA 1500; HCFA 1450 (UB-82, UB-92), Universal Billing Form (NCPDP-approved) for pharmacy claims, and the DA Dental Form for dental claims.

Collection of Information to Support a Unified Database

For identification of claimants and providers, EBD accepts social security numbers and tax identification numbers.

EBD collects data elements that are anticipated to be needed for a unified database and that are expected to be included in the standardized formats that may be developed in the future.

More information would be needed about which common local coding requirements and which local field indicators in order to respond to this entry.

NWNL EBD has system edits and audits to validate procedure and diagnosis appropriateness and provider qualifications.

Acceptance of Common Coding Schemes

NWNL EBD accepts CPT, HCFA (HCPCS), ICD-9-CM, DSM III - R, ADA, and Revenue Center Codes (UB codes). National Drug Codes (NDCs) are not currently required but could be utilized in the future.

Move to Adopt Workgroup on Electronic Data Interface (WEDI), or Other National Efforts Towards Electronic Standardized Formats

NWNL EBD is moving toward utilizing WEDI standards and will continue to do so through 1994.

Procedures to Conduct Internal Performance Monitoring

NWNL EBD continually seeks to monitor all the elements mentioned: administrative costs, responsiveness to patients and providers, timeliness, and general responsiveness in providing service.

There are measurable claims processing performance standards that evaluate timeliness, quality, accuracy, and pricing.

Other Strategies

NWNL EBD has instituted a division-wide quality improvement process targeted to continually work at improving uniformity, reducing costs and administrative processes, and enhancing the quality of our service.

Area Five: Third Party Liability

Coordination of Benefits

- (a) COB information is updated yearly via enrollment forms or more frequently via letter request if information on incoming claim raises questions.
- (b) Our goal for response to any inquiry is five working days.
- (c) Our goal to process a claim is five working days.
- (d) Not aware that CBA's are done at this time.

Other

We are in the process of cross referencing all claims paid with various ICDA codes in order to identify third party cases.

We currently receive a list of claims from a third party vendor that contains potential workers' compensation cases.

I hope the above information is useful. If you have any questions, please feel free to contact me at (612) 342-3831.

Sincerely,

A handwritten signature in black ink, appearing to read "Paula Cludray-Engelke".

Paula Cludray-Engelke, J.D.,FLMI,ACS
Manager, Policy Compliance

Enclosures

23. Professional payment mechanisms include resource-based payment approaches, bundled payment approaches, deductibles and co-payments, risk-sharing and referring to provider profiles for calculating reimbursements.
24. Outpatient hospital payment mechanisms include appropriate use of deductibles and co-payments, requiring bundled billing of services, and discouraging the use of emergency room for non-emergency care. PALICO does not however use base fee schedules on resource-based payments.
36. PALICO is currently working on using national formats for enrollment, eligibility, claims submission and payment and remittance advices.
17. Pre payment claims review validates that hospital, physician and outpatient services claims are not in conflict with or exceeding pre-defined limits compared to claims previously adjudicated and identifies providers for review by referral. PALICO also rebundles multiple procedure claims. Post payment review identifies contractual obligations of providers.
18. Internal retrospective review includes secondary review of reviewer decisions, audit or randomly sampled cases for accuracy and consistency of reviewer's judgments. All of these reviews are performed in- house.
19. Drug utilization review is done on groups outside of Montana. We accomplish all of the utilization management listed except for formulary by using drug card vendors, primarily Perform, and NPA.
20. Utilization Management Tracking for Philadelphia American Life includes collection, analysis and interpretation of health care statistical data to determine effectiveness of cost management measures, to design benefits and to better manage care. Currently PALICO does not compare all hospital utilization rates, examine provider practice and referral patterns, compare claims data to norms, analyze monthly utilization , conduct health risk appraisals or access quality of care. PALICO does utilize plan analysis reports to measure the ongoing effectiveness of its utilization review programs. The tracking of utilization review outcome data is produced annually for effectiveness.
25. PALICO does encourage bulk purchasing through competitive arrangements for durable medical equipment, medical supplies, prescription drugs and other services.
32. PALICO uses subrogation and the right of recovery to address accuracy in claims payment, uniformity and reduction in costs and administrative burden.

31. In processing coordination of benefits PALICO uses cost-effective updates of COB information files, timely responses to customer inquiry and timely claims processing. PALICO does not use cost benefits analysis in COB processing.
30. Calculation of average savings to cost ratios to determine cost-effectiveness of Third Party Liability/Coordination of Benefits activities is used by PALICO.
37. PALICO has in place the following procedures to monitor internal performance: ongoing review of administrative costs, responsiveness to patients and providers during claims processing and appeals processes. timeliness and responsiveness. PALICO also measure claims processing performance standards by timeliness, quality, accuracy and pricing.
38. Another innovative strategy used by PALICO is a production incentive program.
39. There is ongoing training of personnel to recognize potential fraud and abuse situations. PALICO does attempt to prevent and detect fraud and abuse and seek criminal prosecutions against providers and patients who commit fraud. PALICO does not have a formal linkage between provider profiling processes and fraud and abuse detection nor do we provide education to providers and patients regarding fraud and abuse policies. We also do not have processes to increase patients' awareness of fraud and abuse.
40. PALICO provides employee bonuses for fraud detection as an innovative strategy to control fraud and abuse.
4. PALICO's plans inside the state of Montana utilize provider networks that compare provider practice patterns based on cost, service use and quality. These participating providers are identified in PALICO's claim processing system. PALICO does provide feedback to the providers for educational purposes and to alter practice patterns. PALICO does offer plans that integrate inpatient services with community health and other ambulatory services.
7. We contract with various PPOs whom we believe incorporate quality improvement and assessment strategies with in their services.
8. Same as #7
9. Same as #7
10. Same as #7
11. Same as #7

33. PALICO accepts the following standardized claims formats, HCFA 1500, HCFA 140, Universal Billing form and the ADA dental form.

34. In order to support a unified database PALICO accepts specific patient and provider identification numbers, would like to see the provider except standardized remittance advice formats and Explanation of benefits, common local coding requirements and local field indicators are used . PALICO also has system edits/audits to validate procedure and diagnosis appropriateness and providers' qualifications.

35. PALICO currently except the following common coding schemes: CPT, HCFA, National Drug codes ICD-9-CM, DSM III AND ADA dental procedure codes. At this time PALICO does not utilize the Revenue Center Codes.

1. PALICO, does not provide benefit packages that use an identified point of entry. PALICO does however provide primary care providers and preventative services on plans outside Montana.

2. PALICO does not provide any benefit packages that include health promotion or promote health education.

21. No additional strategies are applied in utilization management.

22. PALICO's cost management plans for hospital payment do encourage competitive pricing, risk-sharing and appropriately use deductibles and co-payments. Currently, PALICO's cost management plans do not encourage appropriate utilization and use of in-state hospitals if more cost-effective or use Centers for Excellence. At this time PALICO does not calculate rates for services provided based on level of needed resources, or address the itemization of charges where either bundling or unbundling would reduce costs.

26. PALICO does not utilize payment mechanisms to encourage the quality improvement capacities of providers.

27. PALICO does not utilize any other innovative strategies in payment mechanisms.

28. Data matches to other organizations and insurers that capture relevant data is not done by PALICO.

29. PALICO does not provide cost avoidance processing through review of external databases.

thePrincipal

*Financial
Group*

Principal Mutual
Life Insurance Company

March 3, 1994

Dorothy Bradley
Montana Health Care Authority
Box 200901
Helena, MT 59620-0901

RE Health Insurer Cost Management Plans

Please find enclosed the Cost Management Plans.

If you have questions, please give me a call.

Sincerely

Karol Crumes

Karol Crumes, Financial Reporting Specialist
Group Technical Services, (515) 248-8770

Enclosure

INTEGRATED SYSTEMS FOR HEALTH CARE DELIVERY STRATEGIES:

Benefit designs under our Preferred Provider Organizations (PPO's) are based on allowing the insured a choice of using a PPO provider or electing services to be rendered through a Non-PPO provider. The insured can elect providers at point of service based on their individual needs. Our benefit designs do incorporate preventive services as part of our standard plan designs.

Benefit package concerning healthy lifestyle and high-risk conditions enclosed. "Save your Hidden Paycheck."

Our managed care objectives are to help provide our members and their treatment team with quality, cost effective care options. By promoting and encouraging cost containment strategies such as home care and other non-hospital based care early, outcomes from treatment can be enhanced with decreased cost to our customers.

Our PPO networks review utilization, quality, and patient feedback as factors when evaluating providers for the network arrangement. We've identified below additional specific quality and health assessment issues which we have developed. Our PPO networks also internally have their own Quality Assurance programs which are used in their initial provider contracting and ongoing maintenance review of their network providers. The PPO's are also involved in ongoing education efforts with their provider base. Utilization management programs also have criteria guidelines to ensure medically appropriate care options to inpatient settings if applicable.

When we contract with our PPO networks we evaluate a variety of items to ensure we're working with a high quality and cost effective organization. We evaluate a number of factors in our due diligence efforts including staffing levels, accreditation, statistical data, certification, and credentialing practices. We also thoroughly evaluate their utilization management, quality assurance, reporting, reimbursement, and claim practices as part of our review of the PPO arrangement. Our PPO arrangements do enlist a variety of primary care providers within their network so that the insured can elect the appropriate provider based on their needs.

We're continually evaluating our managed care product options to provide our clients with delivery systems that reflect high quality and cost effective approaches. These include enhancing utilization management services, ongoing alternative medical care plan options, primary care plan development, and enhanced health assessment data for evaluation. We identify specific strategies based on individual market developments and our broader managed care strategy evaluation.

PRINCIPAL FINANCIAL GROUP QUALITY ASSESSMENT AND IMPROVEMENT

The Principal Financial Group has focused time and energy on the assessment and improvement of health care services. Our efforts are currently focused on assessment of health care costs, utilization, and quality. In the near future, we plan to begin implementing improvement programs to actively pursue improvement of health care delivered.

The goal of The Principal health care quality assessment and improvement effort is to identify inappropriate, unnecessary, and inefficient health care as well as to improve medical and cost outcomes to optimal levels. Our strategy can be reviewed using the Structure, Process, and Outcome model for health care quality assessment. Each measurement and assessment listed in this model is explained in detail under the Measurement and Assessment section. Our plans to use this information to improve the quality of care delivered to plan members is provided in the Quality Improvement Plans section.

STRUCTURE, PROCESS, OUTCOME.

STRUCTURE:

attribute

Accessibility

measurement/assessment

GeoAccess patient/physician mapping software

Staff Qualifications

Credentialing/Provider selection programs

PROCESS:

attribute

Coordination of Care

measurement/assessment

Physician referral pattern analysis

Appropriateness of Care

Precertification of stay

Pre-Treatment review

Analysis of diagnoses not normally hospitalized

Physician Profiling

Drug utilization review

Hospital efficiency analysis

Ambulatory efficiency analysis

Physician profiling

Efficiency

OUTCOME:

attribute

Cost of Care

measurement/assessment

Hospital efficiency analysis

Ambulatory efficiency analysis

Readmission analysis

Mortality studies

Preventive health screens

HEDIS Quality Indicators

Medical Outcome

MEASUREMENTS AND ASSESSMENTS

DATA SOURCES

The principal sources of the data we use to assess health care originate from administrative data sets. The source documents are typically the UB 92 and HCFA 1500 uniform billing forms. This data includes clinical indicators as well as cost and utilization indicators. We use this information to produce specific report formats and analysis that measures the efficiency and quality of health care. Our measurements and assessments provide employer, plan, and provider level analysis.

SPECIFIC MEASUREMENTS AND ASSESSMENTS

HOSPITAL EFFICIENCY ANALYSIS

Length of Stay

This set of measures profiles costs and utilization performance of hospitals.

Average total length of stay.

Average vs. expected length of stay (case mix adjusted by DRG age/gender groupings)

Average charge

Average charge vs. expected average charge

Discharge Rates

Total discharges

Discharges /1000

Discharges /1000 actual vs. expected discharges /1000

Days of Care

Total discharges

DOC /1000

DOC /1000 actual vs. expected DOC /1000

Analysis

The hospital efficiency measures are analyzed using key variables. These variables are DRG, MDC, ICD9-CM Procedure and Diagnosis codes, CPT codes, geographic location, hospital name and I.D., attending physician, age/gender groupings, provider type, and service type.

AMBULATORY EFFICIENCY ANALYSIS

Payline Analysis

Total charge per member

Paylines /1000 insureds

Paylines /1000 members

Amount paid per member

Total charge per payline

Physician Practice Pattern Analysis

Number of patients analyzed

Total paylines

Total patients

Total charge per patient

Amount paid per patient

Ambulatory Encounter Analysis

Total encounters

Total charge per encounter

Encounter /1000 insureds

Encounter /1000 members

Total charge per member

Total paid per member

Analysis

The ambulatory efficiency measures are analyzed using key variables. These variables are age/gender groupings, claimant, employer, location, MDC, CPT category, CPT groupings, Provider I.D. and name, provider type, and service type.

PHYSICIAN PROFILING

Provider Profiling

The Principal is currently installing a provider profiling report system to monitor physician cost, utilization and quality. This set of reports will allow for specific analysis of physician practice. We have targeted a group of specific patterns to evaluate as well as a set of quality indicators that have been outlined by the NCQA HEDIS effort.

Physician Evaluation Report

This analysis reviews charges and utilization per member per month and ranks each physician according to performance measures. The measures include inpatient discharges, outpatient surgeries, office visits, ancillary services and all services combined. This will allow us to track the primary care physician as a manager of care. All services provided the patient are included including specialist referrals and ancillary services or procedures.

Actual Charges Compared to Expected Charges

Plan physician per member per month charges are reviewed by comparing actual charges to what charges would be expected given the case mix and severity of the patient population. The severity and case mix adjusting for ambulatory visits and services is performed by grouping patients by the Ambulatory Care Grouping system developed at Johns Hopkins. The hospital based services are adjusted by age and gender grouping by DRG. These expected values are developed this way for all Physician Profiling reports.

Charges for Hospital Based Services

In this report, Plan physicians are analyzed by their patient's inpatient charges and outpatient surgery charges. The actual per member per month charges are compared to expected charges.

Charges for Ambulatory Services

Ambulatory charges per physician are detailed. Visits and ancillary services charged per member per month are compared to expected charges.

Ambulatory Referrals

This analysis provides information on the physician referral pattern and on their service intensity. The percent of visits and ancillary services referred are compared to the total services in each category. A percentage of referred care is developed for each physician and thus referral patterns can be analyzed.

Physician Report Card by Rendering Physician

Each physician is analyzed for charges based upon delivery site. These performance measures are inpatient discharges, outpatient surgeries, office visits, ancillary services, and all services. Total charges, charges per patient, and utilization rates where appropriate are reviewed. Physicians are assigned a rank as to how they compare when actual to expected charges and utilization are reviewed.

Actual Utilization Compared to Expected Utilization

This analysis reviews utilization in three areas by physician. These areas are inpatient length of stay, ambulatory visits, and ancillary services. Physician performance is compared by displaying ratios of actual performance compared to expected performance. Actual results are also displayed in a companion report.

Preventive Health Screens

This report shows preventive health care performance by provider. The preventive areas analyzed are immunizations, mammography tests, pap smear tests, and cholesterol screens. Actual physician performance is compared to the expected performance rates for the physician's patient population. The expected rates can be assigned by studying our experience or assigning benchmarks per public health data. This report provides an indirect measure of medical outcome. For example, children who are immunized against measles are less likely to experience a disability due to measles. Women screened regularly for breast cancer are less likely to die from breast cancer.

HEDIS Quality Indicators

This analysis provides information on the overall performance of the plan as measured by the quality indicators developed by the NCQA. These measures include elements of preventive care, prenatal care and delivery, chronic conditions such as asthma and myocardial infarction, and affective disorders. Plan results are compared to the target percentages adopted from the "Healthy People 2000" report.

C-Section Rates

This analysis compares the number of C-section deliveries by gynecologist to the number of total deliveries. Charges of all deliveries compared to C-section deliveries is also compared by physician.

Readmission Analysis

This analysis reviews multiple admissions for the same patient by physician. A readmission rate is developed for all plan physicians. Possible quality problems can be identified by physician. The ability to examine readmission by hospital is also available in the Hospital Efficiency Measures.

Practice Pattern Analysis

This analysis will review physician charges and paylines by high volume diagnoses such as back strains and sprains. Any ICD9-CM diagnoses code can be reviewed.

Diagnoses Not Normally Hospitalized

In this analysis we have assigned "flags" to a list of diagnoses that do not normally require hospitalization. Claim activity for these diagnoses is aggregated into specific reports by physician. This report helps to identify possible inappropriate use of medical services as well as identify the effective pre-admission programs or efficient management by the providers.

QUALITY IMPROVEMENT PLANS

The Principal is in the process of developing programs to improve the efficiency and quality of care delivered to our customers, policyholders, or plan members. Some programs envisioned are Credentialing with Data, Targeted Utilization Review, Data Sharing with our networks/physicians, and Fraud Detection.

PLANS

Credentialing with Data

With the completed installation of the physician profiling system we will review physicians and make rankings in regard to several quality issues. This information can then be used to determine physician membership in networks.

Targeted Utilization Review

With the profiling reports, we will evaluate whether it is necessary for particular physicians to be reviewed for each hospital admission or proposed surgical procedure. The objective will be to redirect our U.R. activities to the physicians in need of feedback. Their practice patterns will guide our effort.

Data Sharing with Providers of Medical Services

This effort will provide data in regard to practice patterns and quality/efficiency profiles for physicians and hospitals. The objective is to create a dialogue between providers of service and our health care plans. Given the nature of data and coding problems, our philosophy is that provider efficiency can be determined without a great deal of direct dialogue, but quality can not. Thus, we envision providing health care professionals with information in regard to ranking and practice patterns, but not without a chance for feedback and corrections of possible erroneous coding.

Fraud Detection

Our data systems are useful in looking at abhorrent practice patterns that point to the area of over utilization that can be labeled fraudulent. Our fraud professionals will use the profiling reports and ad hoc analysis capabilities of our hospital and ambulatory efficiency measurement systems to uncover fraudulent practices and gross over utilization.

QUALITY IMPROVEMENT AND ASSESSMENT

Our PPO networks do evaluate quality improvement and assessment processes. They do this through a variety of measurement tools including practice patterns, readmission rates, mortality rates, appropriateness of medical services, patient feedback, and other statistical data to identify quality measurements. Principal Mutual is also very committed to identifying and evaluating health assessment indicators to help in this review process for our internal purposes and as we work with our PPO networks to ensure quality and cost effectiveness through our managed care options. We've provided detail information below on our health assessment activity outlining how we're approaching this area.

UTILIZATION MANAGEMENT

Case management principals are used to manage catastrophic and chronic conditions for our members. The nursing process of assessment, planning, implementation, and evaluation are used to ensure and facilitate quality cost-effective care is being provided along the treatment continuum. Case managers following URAC guidelines and internal claims review procedures to address denials and appeals.

HIL handles the coordination and facilitation of ensuring that member's receive care at the most appropriate level on those cases that require short term case management services that are considered episodic. For those cases requiring long term management, our catastrophic area assumes responsibility for all management. Communication and referral procedures for the transition of cases is seamless to the member.

Pre-payment review

Utilize internal and external review mechanism on pre-authorizations for hospital or professional care to assure compliance for contractual provisions.

Post-payment claims review

Use of internal and external review mechanisms on retro reviews of hospital or professional care to assure compliance of all contractual provisions.

Drug Utilization Review

The Principal currently has access to a prospective on-line information service through a third party pharmacy network. When an on-line alert message appears, the pharmacies may interact with either the patient or the prescriber about the appropriateness of medications, potentially harmful interactions, or the use of formulary drugs. However, we do not currently have this in place in Montana.

The Principal currently is involved in a retrospective drug utilization program which includes data analysis, administrative services, and quality assurance committee support provided by a third party quality assurance company. Our program is only available for our customers having carve-out prescription drug coverage card and/or mail-order programs.

We use detailed claim data to identify patients showing the most potential therapy problems associated with under use, over-use, abuse, inappropriate long-term use, use of generics, drug-drug interactions, contra-indications, poly pharmacy, use of multiple physicians, etc. Our committee communicates with the providers by sending information and educational letters and asks the providers to review specific patients therapy based on this additional information. We don't deny claims based on the utilization review process, but benefit from savings resulting from providers changing prescribing patterns.

We are not currently offering this program within the state.

Preadmission Authorization

The hospital authorization process is used for both elective and emergency admissions. If an inpatient admission is planned far in advance, the patient's attending physician can initiate the authorization process by completing and submitting a Hospital Admission Request form. If the timing before a nonemergency hospital admission is more limited, the employee, a family member, or the physician can call Health Info Line to provide the information on the upcoming confinement.

If the employee or a family member initiates the call, a Health Info Line nurse will contact the physician to obtain a verbal report of the patient's condition and hospital treatment plan. The report includes the following information:

- The reason for the hospital admission and confinement.
- The significant symptoms and physical finding.
- The diagnostic evaluations performed.
- The procedures to be performed during the hospital confinement.
- The treatment plan.
- The estimated length of stay.

Telephone conversations are not recorded. However, all calls are documented on-line.

The length of stay data from the Commission on Professional and Hospital Activities is used as a guideline. Recognizing that these statistics are compiled a year in advance of publishing, we use the 50th percentile of the Western Regional data as the initial authorization. Unusual or complicating factors of each individual situation are considered and reviewed when necessary with our physician consultants before we make a final decision. Specialized length of stay data is also available for some situations (e.g., geriatrics, pediatrics, psychiatry).

In regard to admissions, we have developed our own criteria with the assistance of our physician consultants.

If the appropriate information is available, many of the hospital preadmission authorizations can be completed at the time of the initial call. Delays would be the result of inability to obtain necessary information from the physician adequate to determine medical necessity. In the event that medical providers do not cooperate with this process, medical records will be obtained and the admission will be reviewed on a retrospective basis after all parties have been informed of the circumstances and potential consequences. If a member of our nursing staff is not available, our goal is to return calls within one working day.

An initial confirmation is made on the phone, then letters of confirmation outlining the results of the hospital preadmission authorization and concurrent review are sent to the employee, physician, and hospital. Since the review process is documented in the individual employee record within the claim payment system, it is immediately available to the Regional Claim Center responsible for adjudicating claims. This system also provides follow up and exception capabilities for monitoring current claims.

For an emergency admission, Health Info Line must be contacted within two working days following the hospital admission. If someone other than the physician initiates the call, a Health Info Line professional will call the physician to obtain a report of the information.

Pretreatment Review

Medical research now shows that many procedures and services exceed the accepted practice standards for performance. The Pretreatment Review program concentrates on medical procedures and services that exceed the accepted practice standards for performance. By utilizing an extensive medical criteria base and physician network, Health Info Line prospectively reviews the medical necessity of a proposed treatment to confirm that it qualifies as medically necessary under the benefit plan.

Unlike the early Second Surgical Opinion program or the Presurgery Review programs, Pretreatment Review examines the appropriateness of a wide range of inpatient and outpatient services. In addition to medical procedures and services, reviews of outpatient mental or nervous and chemical dependency treatment are performed. Cosmetic and transplant surgeries are also included in the program. They will be reviewed not only from a medical necessity perspective, but also to determine whether they meet the contractual provisions for coverage.

The Pretreatment Review process is as follows:

For any course of treatment involving the conditions and procedures listed, the member must call Health Info Line. Our registered nurses and physician consultants review the patient's condition and the proposed treatment plan. Information is requested during interviews with the patient and/or attending physician. The information requested for review includes:

- the patient's medical history
- the current symptoms and physical findings
- the results of diagnostic studies
- the attempted medical management to date
- the clinical indication for treatment
- the specific procedures and/or services to be performed during the course of treatment
- the estimated length of treatment

Occasionally, the patient's medical records must be requested in order to obtain this information.

The nurse then applies the information received to the criteria base. The medical criteria base used for review is the "Medical Review System" developed by Value Health Sciences, Inc. The psychiatric criteria base was developed by a panel of psychiatric physician consultants. The criteria reflects national standards for practice developed by national panels of physicians after an extensive review of literature and scientific research.

If the information received is not adequate to certify the medical necessity of the proposed treatment, the case is referred to a physician consultant for peer review. The physician consultant contacts the attending physician direct to discuss the case. The consultant verifies the clinical information obtained by the nurse and seeks exceptional circumstances which would substantiate the medical necessity of the treatment proposed. Once the review is complete, the attending physician and the member are notified by telephone and a letter of confirmation or declination is sent to each party.

Some types of treatment are of an ongoing nature, for example, manipulation therapy or outpatient mental/nervous or substance abuse treatment. The authorization for this treatment may be extended if additional services are considered to be medically necessary. The attending physician must furnish an updated report of the patient's condition and the progress made toward treatment goals. If medically appropriate, the additional treatment is authorized.

A Pretreatment Review is not required for emergency procedures or services. However, if an inpatient hospital confinement is necessary, Health Info Line must be contacted to authorize the length of stay.

If a nonemergency procedure or service is performed and a Pretreatment Review was not requested, the procedure or service is reviewed in retrospect to confirm medical necessity. This review is performed by the registered nurses and physician consultants. No declinations are made without a peer-level physician review.

The member and/or attending physician have the right to appeal any Pretreatment Review declination. The appeal review is conducted by another independent physician consultant. If the medical necessity for treatment fails to be established during the second physician review, an independent medical examination can be arranged at the member's request.

A comprehensive list of conditions and procedures is listed in the members' booklets.

The List of Conditions and Procedures is as follows:

Cardiovascular Conditions

- Carotid Endarterectomy
- Coronary Angiography
- Coronary Artery Bypass Surgery
- Heart-Lung Transplant
- Heart Transplant

Gastrointestinal Conditions

- Cholecystectomy
- Colonoscopy
- Gastric Surgery for Obesity
- Hemorrhoidectomy
- Lipectomy
- Liver Transplant
- Pancreas Transplant
- Upper Gastrointestinal Endoscopy

Gynecologic Conditions

- Dilation and Curettage (D&C)
- Hysterectomy
- Laparoscopy
- Mammoplasty

**Mental/Nervous/Alcohol and Drug Abuse Conditions
Outpatient Treatment**

Ophthalmologic Conditions

- Blepharoplasty
- Cataract Extraction
- Radial Keratotomy
- Strabismus Repair

Orthopedic Conditions

- Bunionectomy
- Carpal Tunnel Release
- Hammertoe Repair
- Jaw Surgery
- Knee Arthroscopy
- Laminectomy
- Manipulation
- Spinal Fusion

Otolaryngologic Conditions

- Adenoidectomy
- Allergy Shots
- Bronchoscopy
- Rhinoplasty
- Septoplasty
- Tonsillectomy
- Tympanostomy Tube Insertion

Urinary Conditions

- Cystoscopy

Miscellaneous Diagnostics and Treatments

- Computerized Tomographic Scan Spine
- Radioallergosorbent Test

Maternity Admissions

Routine admissions for normal vaginal deliveries are authorized according to a separate set of guidelines. Since the current, national trend for normal vaginal deliveries is to remain hospitalized for a two day length of stay, inpatient confinements for this diagnosis are automatically authorized for two days.

No call to Health Info Line is required. However, to avoid a benefit penalty, Health Info Line must be notified on or before the third day if the mother or child needs to stay longer than two days for delivery.

Any admission for a pregnancy related diagnosis other than normal vaginal delivery must be preauthorized according to the standard guidelines. This would include diagnosis such as C-sections, placenta previa, pre-eclampsia, and preterm labor.

APPEALS PROCESS

I. Expedited Appeal (Reconsideration)

A. Definition

A request by telephone, prior to or during the course of treatment, for an immediate review when the attending physician does not agree with the initial determination not to authorize an admission, extension of stay or other health care service.

B. Process

1. Maximum information will be shared by telephone, fax, or in writing to resolve the expedited appeal.
2. Physician Consultant Review.
 - a. If new information is provided, the same physician consultant who made the initial determination may perform the review.
 - b. If no new information is provided, a different physician consultant must perform the review.
3. The Company will provide the attending physician access to the physician consultant, by telephone, as requested.
4. A determination will be made within one working day of receiving the necessary information to complete the appeal.
5. Notification of the determination will be made by telephone and in writing to the attending physician, hospital, and member/patient within one working day of the decision.
6. Upon request, the attending physician will be provided with the clinical reasons for the determination not to authorize.
7. Expedited appeals which do not resolve a difference of opinion may be resubmitted through the standard appeal process.

II. Standard Appeal-

A. Definition

A formal written or telephone request, prior to, during, or following a course of treatment , to reconsider a determination not to authorize an admission, extension of stay or other health care service.

B. Process

1. The documentation required by The Company may include copies of part or all of the medical record and/or a written statement from the Health Care Provider. (Only the necessary or pertinent sections of the medical records should be requested)
2. A physician consultant who did not make the original determination not to authorize will conduct a review of the documentation provided.
3. A determination will be made within 45 days of receiving the necessary information to complete the standard appeal.
4. Notification of the determination will be made in writing to the attending physician, hospital, and member/patient within two working days of the decision.

5. Upon request, the attending physician will be provided with the clinical reasons for the determination not to authorize.

6. When an appeal to reverse a determination not to authorize is unsuccessful, a physician consultant in the same or similar specialty as the attending physician will perform the review. Follow the same review and notification procedures outlined in number 3 and 4 above.

NOTE: A physician consultant in the same or similar specialty as the attending physician should be made available, upon request, at any time during the appeal process, when reasonably possible.

Concurrent Review

Concurrent review is performed on the anticipated date of discharge. Our computerized utilization review system has a concurrent review feature, which automatically generates daily computer listings. These are sorted by hospital and time zone of the hospital on those cases scheduled for discharge that day. If the patient remains confined, the Health Info Line nurse will assume responsibility for initiating the concurrent review. The physician is then contacted to furnish an updated report on the patient's condition and treatment plan. The information concurrently reviewed includes:

- The reasons for requesting additional hospital confinement (i.e., current symptoms and physical findings).
- The procedures to be performed during the extended confinement.
- The treatment that will continue to be provided.
- The estimated length of additional hospital confinement.

Based upon a review of the new information provided, an extension of the hospital authorization may be approved by Health Info Line. If the proposed extension is found extreme, an alternative treatment setting or nonhospital treatment options will be suggested. The nurse reviewers are highly involved with discharge planning when developing an alternative to hospitalization.

The majority of our continued stay reviews are performed via telephone. On site reviews are limited to select hospitals where the number of admissions are high enough to make on site reviews cost effective.

Case Management Referral

An extremely important aspect of the Hospital Preadmission Authorization process is that it provides for timely referral to our large case management department called Alternative Medical Care (AMC). The AMC nurses are responsible for exploring quality, cost-effective alternatives to otherwise medically necessary care. In the course of an authorization, the Health Info Line computer system recognizes diagnosis codes and repeat admissions. This data will "force" a referral to AMC for in-depth evaluation and possible intervention.

Cases are also identified through referrals from agents, planholders, physicians, and health care providers who are familiar with our case management services. A smaller percentage of cases are identified through our computer system, which automatically prints out claims with specific diagnostic codes which have draft payments of certain dollar limits.

Throughout the case management referral process, we communicate with all providers, as well as the patient and family. We explain the plan provisions in regard to the procedures, services, and equipment being discussed in conjunction with the treatment plan and possible alternatives. For example, our standard provision permits rental of durable medical equipment. However, we review individual situations and in long term situations where purchase would be more cost-effective, an exception can be made to purchase the durable medical equipment.

The AMC Department is staffed by registered nurses who have experience in such areas as: psychiatry, chemical dependency, medical-surgical nursing, intensive care, coronary care, pediatrics, geriatrics, neonatology, obstetrics, orthopaedics, private duty nursing, public health nursing, and rehabilitation. Each AMC nurse is empathetic, articulate, and knowledgeable in benefit plans. Their expertise in benefit plans enables them to develop alternative care programs for only those cases where the customer would otherwise have plan liability.

When necessary, our nurse case managers review treatment plans and alternative options with our physician consultants. Our consultant base includes both generalists and specialists from various arenas.

In some situations, we may request an independent medical evaluation. Or, we may consult the American Psychiatric Association for assistance.

The cases selected for case management intervention are based upon the patient's diagnosis, treatment plan, and potential for cost-effective alternatives. Examples of such situations include:

- a. AIDS/Pneumocystis Pneumonia
- b. Newborn conditions, including but not limited to:
 1. AIDS
 2. Prematurity
 3. Respiratory Distress Syndrome
 4. Short Gut Syndrome

- 5. Hyaline Membrane Disease
 - 6. Ventilator dependent infants
 - 7. Congenital anomalies
- c. Ventilator Dependent Patient
 - d. Major trauma and neurological conditions
 - 1. Traumatic brain injury
 - 2. Spinal cord injury
 - 3. Burns
 - 4. Multiple fractures or injuries
 - 5. Guillain-Barre Syndrome
 - 6. ALS (Lou Gehrig's Disease)
 - 7. Coma
 - e. Inpatient programs involving:
 - 1. Rehabilitative programs
 - 2. Hyperalimentation (TPN)
 - 3. IV Antibiotic therapy
 - 4. Chemotherapy
 - 5. IV Pain Control
 - 6. Transplants of any kind
 - f. High Risk Pregnancies:
 - 1. Hyperemesis
 - 2. Premature labor
 - 3. History of premature labor
 - 4. History of multiple births
 - 5. Diabetic mothers
 - 6. Placenta previa
 - g. Request for:
 - 1. Purchase versus rental of equipment
 - 2. Day or partial hospitalization program
 - 3. Alternative treatment facility (i.e., residential treatment, halfway house, group home, etc.)
 - h. Length of Stay
 - 1. Two or more related admissions in the last six months
 - 2. Any inpatient stay greater than 14 days

i. Chronic Conditions

1. Any terminal or progressively deteriorating disease requiring long-term care

Quality Review of Service

Quality Control

1. Performance standards have been established and internal quality review of services is ongoing in conjunction with established quality goals. In addition, annual surveys are conducted to obtain information from our customers.
2. The Health Info Line utilization review system has a quality assurance feature which allows the management staff to randomly and selectively evaluate the accuracy of each staff person's review activity. Statistics on accuracy are entered into the computer for daily and monthly monitoring of overall performance.

Included in the quality reviews is service observing which allows management to monitor the telephone protocol of the staff members.

Results of our customer service survey are attached.

Quality review scores

1991 - 98.9%

1992 - 98.5%

In addition, each year a customer service survey is conducted to measure customer satisfaction in the following areas:

- Promptness
- Courtesy
- Accuracy
- Clear communication
- Willingness to meet needs
- Availability to assist
- Overall service

ALTERNATIVE MECHANISMS FOR PAYMENT TO PROVIDERS STRATEGIES

Our case management area encourages the use of specialized, nationally recognized facilities for treatment that have demonstrated their effectiveness based on patient centered outcomes. Quality care promotes faster recovery with fewer complications, and often results in more cost-effective care.

We utilize an unbundling program that addresses professional services billed with CPT codes regardless of locations: office, clinics, inpatient hospital, and outpatient hospital. Utilize programs that require a cost-sharing part on the insureds part for more expensive care (ie. inpatient confinements). We have available a program of a resource-based schedule for all professional charges.

We have a program that will utilize a program for payment based on a resource-based schedule for outpatient charges. Utilization of copays and deductibles for outpatient hospital services include a bundling program on all billed charges. Require satisfaction of copay and deductibles for non-emergency use of hospital facilities.

Third Party Liability/Coordination of Benefits Strategies

We utilize NATIONAL DATA MATCH COMPANIES to track or pursue sources of other group health insurance coverage. We utilize NATIONAL RECOVERY COMPANIES to pursue sources of third party involvement and reimbursement. We utilize in-house Subrogation Unit to pursue and investigate third party involvement and reimbursement.

Use of savings to benefits and costs are utilized to determine affects of third party liability/coordination of benefits.

Coordination of benefits:

- timely-current update of cob information;
- time limits on responses to customer claims;
- use of phone information to avoid delays;
- waive investigation, if possible, on claims where benefit liability is below a predetermined dollar amount.

ADMINISTRATIVE METHODS

The Principal Financial Group accepts all the standardized claim formats.

We utilize Provider Tax Information Numbers for provider identification. For employee/members, we utilize Social Security numbers. Our department information is stored within a family unit concept.

It is our understanding there has not been a standardized remittance advice format established. However, we are interested in standardizing as much as possible in order to reduce costs and provider consistency to our customers.

It is our understanding that there has not been an established standardized EOB format. However, we are interested in standardizing as much as possible in order to reduce costs and provide consistency to our customers.

We accept CPT/ICD-9 coding standards. In addition, there are state coding standards established within the UB82 coding manuals. In order to move to a national data base and reduce overall administrative expenses for insurers who service multiple states, it is important to utilize standard coding.

We accept local field indicators. If this is referring to UB82/92 coding, this is standardized coding.

We have edits within our systems to validate appropriate diagnosis. We also track the provider specialty within our claim system.

Principal accepts all the common coding schemes with the exclusion of National Drug Codes (NDC's).

We are actively working to adopt all national electronic standards.

We have extensive monitoring procedures in place to review our administrative costs, service timing, and quality.

We are actively involved in committees that are directly related to uniformity in our industry. This includes representatives on the ANSI Task Force, HIAA, CHMIS, etc.

The Principal Financial Group is a strong supporter of the goals and objectives of WEDI (Workgroup on Electronic Data Interface) and has had representative present on various sub-committees/TAGs (Technical Advisory Groups).

With respect to enrollment and eligibility, we are moving toward adoption of the ANSI (American National Standards Institute), but have not yet completed this effort. we are able to receive enrollment data via tape submission and have capabilities to allow our customers to enter enrollment information through remote PC dial-up. We are working toward ANSI compliance on claim submissions and expect to be able to receive claims data via NEIC in the ANSI 837 format by second quarter 1994. We are also moving toward electronic remittance and electronic fund transfers using the ANSI 835 format and our goal is to complete this effort in 1994.

As mentioned, The Principal Financial Group is a member of NEIC and we are currently receiving electronic hospital, physician, and dental claims through the NEIC network.

ANTI-FRAUD

The Principal is currently training all of our group claim centers on fraud detection and control. We have developed a video program as well as training modules to provide our staff with the most current information of potential fraud schemes and how to detect and handle these cases.

We have also developed potential fraud indicators and distributed those directly to our claim centers. We have a dedicated special investigations unit that handles the review process and are a corporate member of the national health care anti-fraud association.

We maintain an 800 fraud hotline number that is listed on all of our EOB'S. This enables the insured to contact us for any questions or concerns.

The Principal has initiated several new programs such as the video training, the 800 numbers on our EOB'S, and training for fraud detection for all examiners.

**PROVIDENT
LIFE AND ACCIDENT
INSURANCE COMPANY**

1 FOUNTAIN SQUARE
CHATTANOOGA TN 37402

March 21, 1994

Mr. Mike Criag
Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

RE: Cost Management Plans Survey

Dear Mr. Criag:

Please find enclosed copies of two manuals which will inform you of our present Cost Management Plans. This information is not in place in the State of Montana.

We currently have one case (Huntley Project School District #24) being serviced in your State. This case which is handled in our Select Group Department, has Proview Plus, and no other cost management features listed in the attached manuals are in place.

We feel the data provided will explain the cost management features that are available, but not presently utilized (other than Proview Plus) in your State.

If we can be of further assistance, please let us know.

Sincerely,

Roberta McCain

Roberta McCain
Contract Analyst Assistance
(715) 755-1967

Enclosures

cc: Janet Doty

MANAGED CARE SERVICES

Provident offers a variety of managed care services to help you contain costs without cutting corners on employee benefits. The programs are integrated to work together and are compatible with Provident's computer claims system.

Managed health care services outlined in this proposal are:

- * **PROVIEW^R utilization review service helps you manage your group's health care costs by helping your employees avoid inappropriate hospital admissions and the overuse of hospital services.**
- * **PROVIEW Value-Plus, which identifies specific high dollar diagnostic and surgical procedures for medical appropriateness to further help your employees avoid unwarranted medical procedures and hospital admissions.**
- * **Provident's Mental Health Care Management service, which can help manage your cost of providing mental health and alcohol and drug abuse benefits.**
- * **Case Management Services identifies and works with potentially catastrophic cases to reduce their financial impact on your group plan, while assuring quality care for patients.**
- * **Managed Second Surgical Opinion (MSSO) service helps your employees in two ways: to locate qualified physicians for second surgical opinions when they are needed and also to eliminate the requirement for a second opinion when surgery is clearly indicated. This saves your employees the unnecessary inconvenience of seeking a second opinion and saves your benefits program the cost of the second opinion.**
- * **Handle With Care special maternity program is an employee benefit designed to reduce escalating maternity-related health care costs by the promotion of healthy prenatal lifestyles and the appropriate usage of available health care resources.**

**PROVIEW
UTILIZATION AND CONTINUED STAY REVIEW PROGRAM**

INTRODUCTION

Provident Life and Accident Insurance Company is pleased to present this proposal for the administration of a utilization review program for New Mexico State University. You can be sure that the services outlined within the proposal are accompanied by our full support to assure you of a successful and effective utilization review program.

PROVIEW is an in-house, Provident-developed utilization management program offering utilization review on all inpatient hospital admissions and a length-of-stay assignment with continued-stay review. It puts you more in control of your plan's health care costs by advising and identifying inappropriate hospital confinements by reviewing for medical necessity of care and, when inpatient care is appropriate, continuing to monitor their care in the hospital to assure continued medical necessity and assist with confinement lengths of stay.

PROVIEW is more than a cost-control program. The professional staff at PROVIEW carefully evaluates each case to make sure your employees get quality medical treatment. Following is a full description of PROVIEW.

MORE ABOUT PROVIEW

PROVIEW can control health benefits costs for New Mexico State University by helping your employees avoid inappropriate hospital confinements. When inpatient care is medically appropriate, PROVIEW can reduce the length-of-stay by cutting the number of unwarranted days spent in the hospital.

The PROVIEW program is managed by experienced health professionals, physicians, and registered nurses. For any inpatient hospital admission, PROVIEW must be contacted and provided with the diagnosis, proposed treatment, length-of-stay, and demographics. Professional medical personnel will evaluate the medical appropriateness of the hospital admission. They will also provide recommendations to the physician when second opinions or outpatient surgery may be appropriate.

PROVIEW's recommendation on the medical appropriateness of inpatient treatment is provided over the phone to the physician. To verify the phone conversation, follow-up letters are sent to the patient, the patient's doctor, and the hospital.

PROVIEW can help control costs by avoiding inappropriate hospital admissions, but PROVIEW is more than a cost-control program. With PROVIEW, you can help your employees get quality medical treatment while controlling your company's health care costs. The professional staff at PROVIEW carefully evaluates each case to make sure your employees get the best possible medical treatment. The final decision as to whether to perform a procedure, admit a patient or continue hospital confinement rests with the patient and his or her physician. However, failure to comply with the recommendations of the PROVIEW staff may affect the patient's medical benefits. The appeals process is always communicated to the patient and the physician when a procedure or hospital stay is disallowed.

Because Provident takes care of almost every detail, PROVIEW requires only minimal administration from your company. To help the program run smoothly, Provident's involvement begins before PROVIEW is implemented. With the help of sample announcement letters provided by Provident, your company can inform physicians and hospital administrators about the PROVIEW program and how it affects them.

Provident works with your company to inform your employees about PROVIEW before the program begins. At your company's request, Provident will train your key personnel to answer questions from employees after PROVIEW is implemented. Also, Provident specialists are available to assist with employee meetings to explain the program. Employee educational materials are available which explain PROVIEW and answer frequently-asked questions. Identification cards are also included. These cards contain all pertinent information related to the PROVIEW program.

ADMINISTRATION AND OPERATION

PROVIEW is administered by Provident's Medical Review Management staff located in Chattanooga, Tennessee. The program is operational Monday through Friday between the hours of 8:00 a.m. to 4:00 p.m. in all time zones. The services are easily accessed via one nationwide toll-free telephone line.

Provident's PROVIEW program provides utilization review with a continued stay review feature for all hospital admissions. The continued stay review process provides assignment of a length of stay with a call-back feature to the admitting physician by the PROVIEW Nurse prior to the expiration of the assigned length of stay to verify that the discharge occurs as planned or to determine if any additional days of hospitalization are required. The PROVIEW program completely monitors the hospitalization from the time PROVIEW is notified of a planned or emergency admission until the time the patient is discharged. When appropriate, the PROVIEW Nurse discusses treatment alternatives and special plan provisions such as extended care facility, hospice and home health care with the attending physician. Cases requiring special management and intervention into the discharge planning activities are automatically referred to our Case Management Services program for evaluation and management.

When a physician recommends an elective hospital admission for the employee or dependent, the physician or patient representative should call PROVIEW prior to admission. The Nurse reviews the details of the proposed admission and treatment, and determines, based on criteria, whether the admission is medically appropriate. In the case of an emergency hospital admission, PROVIEW should be notified within two working days of the admission.

The attending physician is given verbal notification of the PROVIEW recommendation at the time of the call. Written confirmation is mailed to the employee, the hospital, and the attending physician within 24 hours of the phone call.

PLAN DESIGN

In order to encourage employees to use PROVIEW, we recommend that New Mexico State University provide incentives for employee participation in the PROVIEW program. Incentives should be of sufficient magnitude to create a direct financial impact on the employee. However, the benefit differential for non-participants should not be so great that it is perceived to be punitive (zero coverage, for example).

Provident recommends that the first \$500 of the hospital's charge for covered expenses for each hospital admission be excluded from covered expenses if the PROVIEW program is not utilized, or if the admission does not comply with the review determination.

In addition, at the time the PROVIEW program is implemented, it would be appropriate to review the entire benefit plan for the purpose of including additional cost management features.

IMPLEMENTATION

Excellence in communication is a key factor in the successful implementation of PROVIEW. Employee orientation/education materials produced and provided by Provident are intended to successfully communicate the benefits of PROVIEW to your members.

Successful implementation of PROVIEW requires the timely completion of several key events. Provident normally recommends a lead time of at least sixty days for full implementation of the program.

The major activities which must be completed are shown below:

SIXTY DAYS PRIOR TO THE EFFECTIVE DATE

- o Consultation regarding revision in the benefit plan which would discourage unnecessary hospital admissions, and encourage participation in the review program.
- o Ordering of any "custom" materials which the employer chooses to have printed, such as identification cards or employee announcement letters on company letterhead.
- o Send all required start-up information to Medical Review Unit.

THIRTY (30) DAYS PRIOR TO THE THE EFFECTIVE DATE

- o Orientation of the employer's "key" personnel to the PROVIEW Program, so that they will be prepared to answer questions and assist employees after the Program is implemented.
- o Delivery of employee educational materials to employer.
- o Scheduling of meetings with employees to explain the program and distribute the employee educational materials.

CRITERIA

The data compiled by the Professional Activity Study (PAS) of the Commission on Professional and Hospital Activities are used to assign the length of stay. This study takes into consideration the diagnosis, the age, sex, geographical area, and any complications of the medical condition. The data are integrated into the Managed Care files and applied real time during the review process. The data elements are updated yearly.

PROVIEW utilizes nationally accepted practice criteria to determine medical necessity and appropriateness for hospitalization. These protocols are objective guidelines which were developed for use by the nurses in evaluating the medical necessity and appropriateness of a hospital stay. The guidelines are designed to address the question of medical necessity in terms of the severity of the patient's condition, of the intensity of treatment the patient is getting, and of the absence of indications that discharge can or cannot be safely accomplished. Essentially, these criteria statements describe medical necessity without regard to the physician's diagnostic label for the case. These criteria are applied real time during the notification call.

STAFFING

The key personnel responsible for Provident's utilization review program include the Medical Director, Medical Consultants, Medical Review Services Director, Medical Review Services Supervisors, Health Resources Coordinators (registered nurses), and Customer Service Representatives. All professional clinicians are licensed in the State of Tennessee. In addition to the Medical Review Staff, other professional staff members in the Marketing/Consulting unit of the Group Department are involved in the development, marketing, and implementation of utilization review services.

Registered nurses serve as Health Resources Coordinators with physician support provided by on-site medical consultants. The medical consultants may consult other practicing physicians who are specialists in the particular medical area under discussion. These consultants are medical doctors who have come to Provident from private practice to serve as full-time Provident employees.

Our Group Department Vice President and Chief Medical Officer oversees managed care activities and is specifically responsible for Medical Review Services (PROVIEW and Provident Case Management Services), Provident Preferred Networks, medical management policy, and all managed care and utilization review direction, criteria, and related issues.

EDUCATIONAL MATERIALS

The PROVIEW program cannot be effective if it is not used. It is imperative that employees understand when and why the program should be used, and most importantly, how the program is to be used.

The PROVIEW brochures serve as the primary educational source for employees. They supply employees with the information which should be given to their physicians when inpatient hospital-level care is considered. A sample PROVIEW brochure follows.

PROVIEW REPORTS

The activities associated with the PROVIEW program -- number of admissions, number of certifications, and number of disapprovals are captured during the review process. The days requested and days certified are also captured for the PROVIEW program. The information is collected and stored on-line on Provident's PROCLAIM system and is available on computer-generated reports.

On an annual basis, a PROVIEW Evaluation Summary is provided when comparable data is available. The PROVIEW Evaluation analyzes the effects the PROVIEW program has had on your company's number of confinements, hospital bed days, admission rates, and average length of stay.

COST

The price of PROVIEW Plus is \$1.70 per employee per month.

PROVIEW Value-Plus

PROVIDENT'S PROVIEW VALUE PLUS

Each year about 32 million Americans will undergo surgery but only a fraction of these people actually require surgical procedures(1). Some illnesses and accidents could be treated without surgery and in fact, many elective procedures are not necessary at all. It is difficult for patients to know when procedures are medically appropriate but your group plan can include PROVIEW-Value-Plus which lets you and your employees know when procedures may not be medically appropriate.

PROVIEW Value-Plus is an automated precertification system that prospectively assesses the appropriateness of certain high cost, high volume diagnostic and surgical procedures. The program offers two sets of procedures, basic and extended, which include both inpatient and outpatient procedures. These procedures were chosen for review due to either high dollar costs or high volume.

PROVIEW-Value-Plus is a computer based software system using a medical logic tree that evaluates a proposed procedure's medical appropriateness. The software is a product of Value Health Sciences (VHS) and was developed at UCLA in conjunction with the Rand Corporation. The focus of the program is to help reduce medical costs by identifying medically inappropriate procedures that could be treated more conservatively while still maintaining quality care.

The program is an add-on service to the PROVIEW program to further intensify and focus the review. It is an advance beyond our current utilization review program in that both the physician and the patient are interviewed when determining the necessity and appropriateness of a procedure. The patient now has input in the review of his or her proposed medical care. Each review is procedure specific and the patient is evaluated on whether or not a procedure is medically appropriate based on the patient's history and previous medical care. This program is a replacement product for Managed Second Surgical Opinion Program and targets the highest cost tests and procedures.

(1) National Center for Health Statistics, Advancedata, 1988

ADVANTAGES OF PROVIEW VALUE-PLUS

PROVIEW Value-Plus allows Provident to provide the following advantages to employers:

- identifies and helps prevent the occurrence of procedures which are medically unwarranted, thus helping to reduce unnecessary medical costs
- identifies appropriate procedures and eliminates the need for additional review
- patients participate in the process and become more aware of treatment options and treatment costs, thus making them more informed consumers
- promotes quality care by eliminating the risks that may be associated with unwarranted treatments
- helps control cost by substitution of more appropriate, less invasive services in place of procedures determined to be inappropriate

HOW PVP WORKS

When a patient is advised by a physician to have one of the procedures included in the PROVIEW Value-Plus program, the patient or the physician calls 1-800-621-4309. Nurses will review the patient's medical information. The list of procedures that must be reviewed will be included in the employees' benefit booklet and will also be available from the employer.

The basic list includes:

adenoidectomy	dilation and curettage
bunionectomy	hemorrhoidectomy
cataract extraction	hysterectomy
cholecystectomy/laposcopic	knee arthroscopy
cholecystectomy/open procedure	lumbar laminectomy
coronary angiography	tonsillectomy
coronary artery bypass	tonsillectomy/adenoidectomy

The expanded list includes these additional procedures:

CT-scan-lumbosacral spine	MRI-lumbosacral spine
carotid endarterectomy	myleogram-lumbosacral spine
carpal tunnel release	imaging
colonoscopy	PTCA (percutaneous transluminal
cystourethroscopy	coronary angioplasty)
hammertoe repair	UGI endoscopy
hysteroscopy	pelvic laparoscopy
hysteroscopic endometrial	septorhinoplasty
ablation	tympanostomy tube insertion
hysteroscopic myomectomy	lumbar spinal fusion

All procedures are reviewed prospectively. A **four (4) working day notice** is required in order to complete interviews with the patient and the attending physician. Failure to call for precertification or notification of less than 4 working days may result in a reduction of benefits.

If criteria for appropriateness are met, the nurse provides verbal notification over the telephone. Written notification is mailed to the patient and the certification process is completed.

If appropriateness criteria are not met, the case is referred to the Physician Advisory Review Panel for consultation between the attending physician and an MD in the same specialty. A determination as to the medical appropriateness of the treatment is made after or during consultation. If the procedure is deemed not medically appropriate the procedure is denied. The final decision as to whether to perform the procedure rests with the patient and the provider. However, denial of procedures may affect the patient's medical benefits if the procedure is performed. If the procedure is denied

the physician and the patient will receive written notice of the denial. Both the physician and the patient have the right to appeal all denials. The appeal will be reviewed by a physician not involved in the original decision. A second level appeal is conducted by an independent physician panel. The second appeal decision is final. Please see attached diagram of the process.

PRICE

As an add-on to PROVIEW, the price of PROVIEW Value-Plus is \$0.50 per employee per month for the basic list of procedures and \$0.80 per employee per month to include the expanded list. No other combinations of procedures are available at this time.

MENTAL HEALTH CARE MANAGEMENT

MENTAL HEALTH CARE MANAGEMENT

The national cost of Mental Health/Substance Abuse care has been rising at an alarming rate -- some estimates peg the increase at double the medical inflation rate.

To combat this trend, Provident established a separate Mental Health/Substance Abuse review called Managed Behavioral Solutions.

What does Managed Behavioral Solutions (MBS) offer clients?

Customers can choose from four levels of managed behavioral care, depending on the degree of intervention they prefer. The four levels are:

- ◆ Utilization Review Notification System -- Utilization Review at its most basic, requiring mental health care facilities to contact us when they admit Provident-insured patients. Outliers are screened and heavily managed.
- ◆ Utilization Review Notification with Case Management -- Includes the previous program and requires that case management take place on every admission.
- ◆ Utilization Review plus Peer Review -- Provides physician-to-physician review of all cases.
- ◆ Utilization Review and Network Development -- Includes the first three Managed Behavioral Solutions programs and offers -- on a case-by-case basis -- the development of a managed-care network of providers and facilities.

Managed Behavioral Solutions can also enter risk-sharing arrangements with certain level-four managed care customers. These arrangements, however, are not appropriate for all employers and availability is limited.

What advantages does Managed Behavioral Solutions offer the customer?

Managed Behavioral Solutions can produce savings for customers at a rate of \$3 saved for every \$1 spent on cost-containment measures. Because 40 to 50 percent of all inpatient care is not medically necessary and could take place outside the hospital at one-fifth to one-tenth the cost, Managed Behavioral Solutions can reduce the actual cost of care, not merely lower the rate of increase.

When integrated with an entire Provident benefit package, Managed Behavioral Solutions can save administrative costs, too. Such an arrangement eliminates the extra administrative overhead that multi-carrier plans often require and reduces the changes of inter-administrative mix-ups.

CASE MANAGEMENT SERVICES

CASE MANAGEMENT SERVICES

You have probably wondered how potentially catastrophic claims can be identified and managed before unacceptable expenses are incurred. And yet you have also been concerned about maintaining quality care for patients who incur those expenses. Provident's answer is the Case Management Services program.

ADVANTAGES: Case Management Services from Provident

- * **The program identifies potentially catastrophic claims early, before they reach very high levels.**
- * **Case Management Services alerts the patient and treating physician to quality alternative treatment programs.**
- * **Case Management Services features hospital discharge planning.**
- * **The program is fully integrated with other Provident managed health care services and with PROCLAIM, Provident's claims management system.**
- * **Case Management Services is available coast-to-coast, no matter where your group is located.**

This valuable service carefully screens all claims and identifies the cases with potential to incur catastrophic expense. Once the cases are identified, Provident specialists become involved in their management, helping to make sure all parties involved are informed of treatments that are the most cost-effective. In many cases, the alternative methods of treatment are also preferred by the patient, the provider and the employer.

How Case Management Services Works

- * **The screening process begins before treatment, with PROVIEW, our utilization review service for the earliest possible identification of cases with potentially catastrophic expenses. When a case is identified, the PROVIEW staff notifies Case Management Services.**
- * **PROCLAIM, our advanced computer system, flags claims based on type of illness, cumulative dollar amounts, or other unusual circumstances. Also, our claims adjusters are trained to identify potentially large claims during the first steps of claim processing. This early identification allows our claim management centers to monitor expenses before they escalate beyond control.**
- * **Because you are often the first to detect catastrophic illnesses and injuries, Provident can show you how to use our proven claim management controls to more effectively contain costs.**

- * During all screening procedures, we look for more than just the obvious. Provident has the ability to detect less noticeable claims with hidden large loss potential. After a claim reaches a certain dollar amount, it is referred to Provident's Case Management Services staff, at which time the plan of treatment is evaluated for potential cost-effective alternatives.
- * To direct the patient to the most appropriate and cost-effective quality care possible, Provident's claim management professionals follow a specific set of procedures. First, the referral is evaluated for case management potential in our centralized referral unit, which is composed of claims experts and clinical experts. At this time contact is made with the employee/patient to explain the benefits of Case Management Services and to obtain consent to participate and to release information. Next the physician is contacted to explain the program and obtain information about the patient. A case manager then conducts a claim status review to determine appropriate treatment options and assess claim expense levels. The Case Management Services staff also helps to plan the patient's discharge from the hospital and reviews the patient's recovery to ensure that care and services remain appropriate.
- * We do not prescribe treatment nor are we direct service providers. Due to our daily experience handling catastrophic cases our role is to assist the insured, the family and the physician in locating and mobilizing those health care resources which will contribute most to the overall treatment plan.
- * On each Case Management referral, we utilize a combined team of health care professionals and insurance experts. Together these teams work to reduce the fragmentation which often occurs when a patient tries to negotiate an intricate health care delivery system. We plan with the patient and family how to use their benefit dollars most effectively.

COST

The Case Management Services charges are currently calculated in the retention.

MANAGED SECOND SURGICAL OPINION

MANAGED SECOND SURGICAL OPINION

This year, about 32 million Americans will be wheeled into operating rooms to undergo surgery (1). Only a small percentage of these people, though, will require immediate medical attention. Surgery is not the only medical alternative available in many circumstances. Often, another physician may recommend a different, non-surgical treatment. Many elective operations are unwarranted.

Your group medical plan can include a Managed Second Surgical Opinion Program (MSSO) that lets your employees know when a "hands on" second surgical opinion (a medical evaluation by a qualified physician other than the primary physician) is appropriate--and when it's not. If a second surgical opinion is appropriate, Provident can help your employees find a qualified physician for another surgical consultation.

When an employee is advised by a physician to have an elective surgery, he or she calls the Managed Second Surgical Opinion (MSSO) service. Nurses will review the patient's medical information and either waive the requirement for a second opinion or provide the patient with the names of physicians who are willing and qualified to give second opinions.

This service benefits you and your employees in two ways:

- * **First, it helps employees avoid certain surgical procedures** which may be unnecessary by getting a second opinion. Avoided surgery often means avoided or reduced costs -- for you and your employees.
- * **Second, MSSO helps employees avoid the inconvenience** of obtaining second opinions when indications are clear that one is not required. Avoided, unneeded second opinions often mean avoided or reduced costs for your group benefits.

ADVANTAGES: Managed Second Surgical Opinion Service from Provident

MSSO has proven successful for the many customers who use it. It is:

- * **uncomplicated and easy to understand.**
- * **competitively priced.**
- * **available throughout the country.**
- * **fully integrated** with other Provident managed health care services and with PROCLAIM, Provident's claims management system.
- * **staffed by experienced medical professionals**, physicians and registered nurses.

(1) National Center for Health Statistics, Advancedata, 1988

How MSSO Works

1. You identify a target list of elective surgical procedures for which a second surgical opinion is required in order for the patient to qualify for maximum health care benefits.
2. The patient or attending physician calls MSSO, using the toll-free number, when a surgical procedure is recommended.
3. A nurse performs an initial medical review, using medically accepted criteria to indicate the need for proceeding with surgery.

If criteria are met:

4. The nurse "waives" the requirement for a hands-on consultation by a second physician. Verbal notification is given over the telephone, and written notification is mailed to the patient.

OR, if criteria are not met:

5. Names of two or three qualified physicians are provided to the patient if a second surgical opinion is required. The physicians are listed in Marquis' Directory of Medical Specialists or are from the physician panel who are within reasonable traveling distance from the patient.
6. Two forms are mailed to the patient: one to confirm the call and one -- a Second Surgical Opinion Claim Form -- for the physician to complete.
7. The patient selects a physician and schedules an appointment. The consulting physician mails the completed Second Surgical Opinion Claim Form to the appropriate claim office.

When Opinions Differ

- * If the second opinion differs from the first, the patient may elect to get a third opinion, may seek an alternative treatment plan or may proceed with surgery. Benefits would apply according to the provisions of your group plan.

Cost

- * The price of this program is \$0.50 per employee per month.

HANDLE WITH CARE

HANDLE WITH CARE

The Handle With Care maternity program is an employee benefit designed to reduce escalating maternity-related health care costs by the promotion of healthy prenatal lifestyles and the appropriate use of available health care resources.

The program helps you show your employees that you care about them and their health. By promoting healthy pregnancies and the birth of healthy babies, the program has positive effects on both you and your employees, while at the same time positively affecting company operations and costs.

So you may properly introduce the Handle With Care program to employees and complete the administrative arrangements, Provident requires a three month set up period prior to implementation.

ADVANTAGES: HANDLE WITH CARE MATERNITY PROGRAM

- * Enrollment in the program is a simple process: you provide the employee with the program brochure and the employee then makes one phone call to enroll. Provident provides communications support to help your employees understand the program.
- * Experienced health care professionals manage the program, by working with the expectant mother and her physician.
- * The Handle With Care program is a nationwide program, giving all employees access to the program regardless of their location.
- * Provident encourages and stresses the importance of your involvement in the program. Your involvement may take the form of in-house educational support, utilization of key personnel (company nurse, and medical staff) to provide additional support, and employer-sponsored incentives. It is critical to the success of the program that you demonstrate to your employees your commitment to the expectant mother's health and the well-being of the baby.
- * Handle With Care tracks standard statistical data and provides this information to you on a quarterly and annual basis.

HOW HANDLE WITH CARE WORKS

The first step in the program is the enrollment:

1. Your staff introduces and educates the employee to the Handle With Care program. The employee is also given a copy of Provident's brochure describing the program. The expectant mother must enroll in the first trimester of pregnancy to be eligible.
2. The expectant mother calls the Handle With Care program, using the toll-free number provided in the brochure. The brochure tells her what information she needs to provide to Provident.

3. Provident's maternity nurses inform the mother about program enrollment procedures, participation requirements and the benefits associated with the program.
4. Demographic information provided during this conversation is entered into PROCLAIM, Provident's computerized claims paying system.

Upon enrollment completion:

1. The expectant mother receives an employee educational package from the Handle With Care program. The educational package contains the following:
 - a. Congratulatory letter from your CEO
 - b. Statement of benefits associated with maternity programs
 - c. Introductory letter from a maternity nurse consultant
 - d. Confirmation statement and authorization for release of medical information
 - e. copy of letter sent to physician introducing maternity program
 - f. 3 educational pamphlets
 - g. What To Expect When You're Expecting, by Arlene Eisenberg, Hiedi Eisenberg Murkoff and Sandee Eisenberg Hathaway, RN, BSN.
2. The expectant mother must sign and return the confirmation statement to Provident in order to complete the enrollment.
3. The expectant mother receives a gift once the enrollment process is completed. She may choose from a car seat, a stroller, a day cradle or a travel tub. The gift is drop shipped directly to the expectant mother at no additional cost.
4. The maternity nurse consultant telephones each program participant for an assessment update of her pregnancy status and re-evaluates for high-risk complications. This contact occurs during the twentieth week of pregnancy and again during the thirty-fifth week. The information obtained from the participant will be shared with her physician as appropriate, and is documented in an individualized case management file. The final contact with each participant is a post delivery call from the maternity nurse consultant.

MORE ABOUT HANDLE WITH CARE

Maternity Nurse Consultant

Handle With Care is administered by a Registered Nurse specializing in maternity care, who assists the expectant mother throughout the pregnancy. The maternity nurse consultant serves as a resource for questions or concerns, is knowledgeable of community resources, and assists the expectant mother and her physician in the coordination of cost-effective care by suggesting treatment alternatives.

Medical Case Management of Complicated Pregnancies

Expectant mothers identified as potentially high-risk or who are expected to have complicated pregnancies will receive Case Management Services. The determination of high-risk is based upon a set of nationally established criteria.

High-risk patients receive monthly follow-up telephone calls from the Case Management Nurse. In addition, the Case Management Nurse makes regular contact with the attending physician and documents these conversations in the case management file. For cases which appear to be very complicated or in which the expectant mother or child appear to be at risk, physician to physician contact between Provident's Medical Department and the attending physician may be initiated by the maternity nurse consultant.

Account Participation

To ensure success, Provident encourages you to take an active participating role in the Handle With Care program. This involvement will demonstrate to your employees your concern and commitment to the expectant mother's health and to the well-being of the expectant baby. The following are ways you can provide educational support:

1. internal education classes and prenatal seminars
2. educational videos and pamphlets
3. educational lending libraries
4. corporate newsletters
5. incorporating company wellness programs
6. occupational Registered Nurses who offer education programs and on-site patient intervention
7. use outside vendors to offer education programs

Provident can provide assistance in communicating the program and educating the employees.

Program Cost

The price of Handle With Care is \$0.50 per employee per month. To intensify the effectiveness of the program, PROVIEW and Case Management must be part of any benefit plan that includes Handle With Care.

PROVIDENT PREFERRED PROVIDER ARRANGEMENTS

Provident Preferred Networks

The Provident Preferred Network (PPN) is comprised of hospitals, physicians and other providers throughout the country who are committed to providing quality care in a cost-effective manner. These providers offer care at negotiated reimbursement rates often below non-network rates. Our PPN program is designed to monitor the use of benefits, ensure medical appropriateness prior to actual use, and then to encourage insured employees to utilize the services of our contracted and cost-efficient PPN providers. The PPN is established in five states and is supplemented by a network of affiliate PPO organizations which operate in 26 additional states, including over 1,900 hospitals and 135,000 physicians. Provident currently has 200 retention accounts representing some 210,000 employees who utilize our network of PPO providers.

The Provident network stands out from the competition in several areas, most notably in our hospital selection process, strict credentialing procedures for physicians, our constant monitoring of physicians and their practice patterns, true physician peer review, intensive reporting procedures and the availability of on-site review of admissions and treatment.

PPN uses good business practices to make the network a win-win situation for employers, employees, providers and Provident. Because customers are rightfully concerned about their employees' health, we carefully monitor network providers to ensure quality care is being given. Because health care costs affect a customer's bottom line, we look at the network from a financial point of view so that PPN can help employers manage their health care costs.

Such an arrangement offers you several advantages:

- * **ease of use encourages employee participation**
- * **freedom of choice of providers for your employees**
- * **on-line integration with Provident's medical review services and claims system**
- * **lower out-of-pocket costs for employees**

PPN is designed to:

- * Reduce hospital admission rates
- * Reduce days per 1,000
- * Reduce length of stay
- * Adhere to strict physician credentialing
- * Profile providers for compliance and adherence to medical management standards
- * Carefully select hospitals and ancillary providers
- * Contract reimbursement rates for inpatient and outpatient utilization
- * Contract physician fee schedules

all to facilitate a consensus of needs among our policyholders, our providers, the patients and Provident.

State Farm Insurance Companies



RECEIVED

Corporate Headquarters
One State Farm Plaza
Bloomington, Illinois 61710-0001

100

March 15, 1994

Montana Health Care Authority
P. O. Box 200901
Helena, MT 59620-0901

Enclosed with this letter is the Cost Management Plan for State Farm Mutual Automobile Insurance Company.

Sincerely,

A handwritten signature in cursive script that reads "Trina Weikel".

Trina Weikel
Staff Assistant

Attachment

I. Integrated Systems for Health Care Delivery Strategies

1. The Basic Hospital Surgical Policy marketed in Montana includes coverage for normal pregnancy expenses. A major medical plan is provided for employees of State Farm who reside in Montana. It provides benefits for routine pregnancy expenses and specific preventative services.
2. The Basic Hospital Surgical Policy offers a no smoking discount.
3. An optional benefits rider is offered on the Basic policy. It provides benefits for outpatient treatment such as physical, occupational, respiratory and speech therapy; outpatient testing following surgery or confinement, and; home health care. The employee group plan provides for a wide range of outpatient services.
4. A preferred provider organization for hospitals has been established for the employee group plan.
5. Besides PPO agreements, vendors are utilized to identify low cost durable medical equipment and supplies. The employee group plan contains a prescription drug program. Other primary care providers are covered since physicians are defined as licensed practitioners who perform services within the scope of the license provided by the laws of the state.

II. Quality Improvement and Assessment Strategies

This section is not applicable to any of our products or procedures.

III. Utilization Management Strategies

11. This is not applicable to any of our products or procedures.
12. Medical case management is utilized in appropriate situations. Their recommendations are useful in benefit determinations.
13. The employee group plan requires pre-admission notification for all hospital confinements.
14. Concurrent reviews are occasionally utilized. However, in a lengthy confinement, a medical case manager would most probably be involved to provide appropriate recommendations.

15. Medical case management would be utilized for any necessary discharge planning.
16. This is not applicable to any of our products or procedures.
17. Independent medical review consultants are utilized for additional claim reviews. A software package is also available to assist with the identification of unbundled charges.
18. Random audits of claims are routinely performed.
19. The employee group plan includes a prescription drug plan which is administered by a vendor. Retrospective review is provided on selected cases.
20. We have no system-supported utilization management tracking capability.

IV. Alternative Mechanisms for Payment to Providers Strategies

22. Audits of selected hospital bills and negotiated discounts are utilized on appropriate cases. All policies include deductibles and co-insurance provisions.
23. A software package is available for assistance with the identification of unbundled charges. All policies include deductibles and co-insurance provisions.
24. All policies include deductibles and co-insurance provisions.
25. Vendors are utilized to identify low cost durable medical equipment and supplies.
26. This is not applicable to any of our products or procedures.

V. Third Party Liability/Coordination of Benefits Strategies

28. Selected injury claims are reported to a national database.
29. This is not applicable to any of our products or procedures.
30. This is not applicable to any of our products or procedures.
31. COB information is automated on the claim system. All claims are subject to time service goals.

VI. Administrative Methods

33. All standardized claim forms are accepted.
34. No plans are being formulated until detailed requirements are outlined.
35. Common coding schemes are recognized and accepted.
36. We are working towards electronic standardized formats.

VII. Anti-Fraud

39. Fraud issues are discussed in procedure manuals. Fraud is also a topic of discussion in seminars.

RECEIVED

TIME

MAY 10 1994

MONTANA HEALTH CARE AUTHORITY

TIME INSURANCE COMPANY
501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
Tel: (414) 271-3011

May 5, 1994

Montana Health Care Authority
P.O. Box 200901
Helena, MT 69620-0901

Re: Cost Management Plan

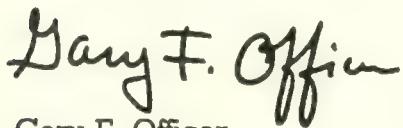
Gentlemen/Ladies:

Enclosed is our Cost Management Plan as requested in a January 7 Memo from Dorothy Bradley.

We apologize for the delay in responding, but this floated around in our company before it got to the appropriate department. At that time, we talked with Mike Craig of your office, who gave us an extension.

If you have any questions or need any additional information, please contact me at the telephone number specified below.

Sincerely,



Gary F. Officer
Compliance Analyst
Law Department
1-800-800-2000, extension 4280

COST MANAGEMENT PLAN

**Time Insurance Company
March 1994**

COST MANAGEMENT PLAN TIME INSURANCE COMPANY

Integrated Systems for Health Care Delivery

Time Insurance Company's current status is one of general insurer providing medical coverage with an integrated utilization review component provided by Private HealthCare Systems, Inc. This program includes pre-admission certification and continued stay review. We further provide case management services for catastrophic cases through an in-house team of nurses who coordinate resources and substitute benefits, as appropriate, in order to provide long-term catastrophic care in the most cost effective manner. Time has introduced a managed care pharmacy network on a national basis which features generic substitution drug utilization review and deeper discounts through selected contracting on a nationwide basis. Time routinely communicates with Pronet, a network of hospital discount arrangements to take advantage of reimbursement arrangements with hospital providers in our non-PPO markets.

Time' current direction is to develop a strong managed care program on a nationwide basis. We currently operate PPOs in over 60 markets, as well as risk bearing point-of-service plans or exclusive provider organizations in San Francisco, Los Angeles, San Diego, Sacramento, Chicago, Phoenix, Dallas, Central California, Boston, and Atlanta. The EPO model, when combined with steep benefit differentials and positive primary care enrollment, has resulted in an increase in service level being rendered by the primary care providers directly or on referral compared to our PPO experience and significantly reduced costs from either our PPO or indemnity experience in these markets. The EPO type plan design further credentials providers to sit not only on licensure and service availability, but also on experience with utilization management as an internal function, rather than an additional burden imposed by the insurance company.

Through Private HealthCare Systems, Time has implemented a national access measurement tool utilizing the geo-access computer mapping software. Through application of this software we were able to constantly analyze the distribution of primary care physicians relative to the 1990 census distribution. By establishing a standard of two primary care physicians within eight miles of each insured, Time is able to produce detail analyses of which communities within a given market meet the standard. This information is used to direct contracting effort at underserved areas and make the most effective and efficient use of administrative resources for the carrier and the network.

Quality Improvement and Assessment

Time currently relies on contracted networks for quality assessment and quality improvement programs. Networks primarily use patient feedback surveys to measure outcomes of care, utilize patient perception of process and treatment as proxies for more statistically significant outcomes measurement. Time currently collects information on statistical treatment pattern and physician treatment pattern. This information is routinely provided for actuarial

analysis, claims review and cost control. Interaction with providers in the majority of settings is primarily a function of Time's contracts with their respective networks. However, direct action and feedback relative to deviations from community standards of office practice administrative procedures and patient outcome is often communicated directly by Time's staff with providers.

Utilization Management

Time routinely applies in-patient readmission certification, out-patient surgical review, length of stay-review and location of care analyses on all admissions and outpatient surgeries. Comparisons are drawn from local, regional and national norms. Intervention and physician practice is inversely proportional to compliance in that providers who submit all information according to utilization guidelines or known expectations receive very few calls from UR staff while physicians who do not attempt to comply are targeted for more intensive intervention. Time's internal large case management department provides a complete array of coordination services to assure the most cost-effective delivery of covered benefits and catastrophic situations.

Through Private HealthCare Systems, Time participates actively in supporting the physician quality monitoring program nationwide in which all participating physicians are credentialed to PHCS standards initially. Then on an annual basis a profile including all claims activity, all pre-cert activity and compliance, any administrative referrals or patient complaints and any specific references in patient satisfaction surveys are reviewed in a recredentialing process. Results of the PQM Program may be termination of provider contract or, depending on severity, frequency, etc. this program can lead to monitoring measurement, evaluation or reward (referrals of new patient requesting redirection to a physician).

Time provides in-house close payment claims review through a combination of automated code review and code usage software, aggressive subrogation, COB fraud and supplemental negotiating staff.

Time's drug program is fully detailed in the first section of this analysis and is applied to all lines of business.

On an annual basis, Time aggregates utilization statistics for each market and each network under contract and evaluates continued participation in these markets and networks through use of comparative data of competing networks and regional and national norms.

Alternative Mechanisms for Payment

In Time's non-managed care markets, Time reimburses according to the 80th, 85th and 90th percentiles of community HIAA data, depending on type of service incurred. Non-PPO hospitals are reimbursed according to the bill of charges submitted for the service. However, claims review, fraud, COB and subrogation review, in addition to proactive non-managed care negotiation services are used to attempt to control costs. In managed care environments, Time is a strong advocate of prospectively set reimbursement, hospital per

diems and per case or DRG based payments as well as standard coding based fee schedules for physician and non-physician providers where possible. Through Private HealthCare Systems, Time has access to a nationwide network of transplant centers or centers of excellence for tertiary care and, many of Time's hospitals are currently being approached to negotiate ambulatory case reimbursement for out-patient surgery on a prospectively set case basis. In Time's EPO model, primary care providers agree to a lower than normal fee schedule in exchange for bonus opportunity of up to 20% of services rendered should total medical costs incurred by the population be held below managed care standards on a per number per month basis. This bonus arrangement in California has resulted in utilization similar to open-access HMO models and a dramatic reduction in medical premiums.

Third-Party Liability and Coordination of Benefits

As indicated in the previous section, Time routinely applies aggressive third party liability and coordination of benefits program utilizing primarily internal resources and staff in conjunction with specific vendors and external investigative programs.

Administrative Methods

Time currently accepts all standardized claim formats and is currently moving toward the implementation of a state-of-the-art claims system able to receive any standardized claim forms electronically and automatically enter the claims into the adjudication system applying all data capture programs and standardized claim review software. Time currently produces standardized remittance advice and explanation of benefits formats and is able to maintain claim turnaround time at or below national standards for similar companies. Time's managed care program has moved to electronic or machine readable data entry and provider updates in order to be able to facilitate accurate contract handling, directory production and claims adjudication.

Anti-fraud

Some aspects of our fraud controls were previously discussed. Other aspects are contained in the attached Policy Statement on Fraud and Abuse.

RECEIVED

MAR 2 - 1994



TRANSPORT LIFE INSURANCE COMPANY

Montana Health Care Authority

EXPRESS MAIL

March 24, 1994

Dorothy Bradley
Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

RE: Montana Cost Management Plan

Dear Ms. Bradley:

Thank you for the due date extension in submitting this plan.

Pursuant to your letter dated January 7, 1994 and Senate Bill 285, enclosed is the Montana Cost Management Plan for Transport Life Insurance Company.

Should you have any questions, you may contact me at 1-800-433-7090, extension 3820.

Sincerely,

TRANSPORT LIFE INSURANCE COMPANY

Sheila D. Cook
Compliance Analyst

SDC/

Enclosures

Cost Management Plan
for
Montana Health Care Authority
March, 1994

**Transport Life Insurance Company
714 Main Street
Fort Worth, Texas 76102**

Topic/Area Six: **Administrative Method**

37. Procedures to conduct internal performance monitoring.

- ① Installed service matrix and ongoing measurement to track performance on basis of accuracy of claim payment (amount, coding and communication), timeliness of processing, and productivity on a per-examiner, unit and department basis. Service matrix developed in 1991, with continued review and revision to improve service and productivity results.
- ① Review administrative costs on a monthly basis. Have analyzed and developed a cost-per-claim index by product line; changes are monitored on monthly basis, with investigation and necessary corrective action resulting.
- ① Developed online mail and phone call logging systems which enable us to monitor communication from insureds and providers. Extensive tracking mechanisms flag us on outstanding aged items or claims with repetitive situations that would indicate that additional communication for clarification is needed.

33. Acceptance of standardized claims formats

- ① We accept all standardized claim formats submitted to us.

36. Workgroup on Electronic Data Interface (WEDI)

- ① We are analyzing the effectiveness and impact of adopting the WEDI or other electronic standardized formats. Part of the consideration will be the appropriateness of this technology for our predominantly supplemental and indemnity products.

34. Collection of information to support a unified database

- ① We will consider coding or formatting changes that will improve our productivity and effectiveness with our customers and providers.

35. Acceptance of common coding schemes

- ① We accept the following coding schemes:
- CPT -HCFA -NDCs -ICD -ADA codes

We have had no claims submitted with NDCs or Revenue Center codes.

38. Other administrative management strategies

- ① Have implemented a work management system, with ability to identify through the combination of specific work assignments and mail control tags the status of all pending and in-process claim activity.

Topic/Area Seven: Anti-Fraud

39. Fraud and abuse controls

- ① Established training on claim fraud and claim abuse detection and processing. All claim examiners receive training upon hire and have an annual refresher course. Seminars on specific abuse/fraud topics are presented as we have a situational need or as we become aware of fraud/abuse patterns through industry associations.
- ① Our Special Investigations Unit (SIU) was established over a year ago. All claims with a potential for abuse/fraud are referred to this unit for analysis by our SIU Analysts. A determination is made as to what investigational activity will be done on a case-by-case basis.
- ① We have been using the services of a major claim abuse/overpayment automated review systems. A system copy of our entire claim file is sent on a monthly basis and run through the program that compare our claim data to a large number of heuristics. Variance from typical care-to-diagnosis, R&C, and a host of other conditions flag those claims on an automated basis for review and potential investigation on a manual basis.
- ① Claim forms have been modified to include a standard statement on claim fraud that informs that knowing and willing intent to defraud or deceive on a claim filing is a felony and that we will actively pursue such action.
- ① We are in the process of modifying our Explanation of Benefits form to add a toll-free number for claimants to report benefits paid for services they did not receive.

40. Other innovative strategies

- ① Under consideration is membership in a database referral system that allows automated access to query on suspect claims. This would assist in the evaluation of our investigational needs and be part of an effective cost/benefit consideration in the control of investigation costs..

Topic/Area Five: Third Party Liability/Coordination

31. Coordination of benefits

- ① For those policy forms with a Coordination of Benefits feature, we process per the contract's provision for COB. However, the majority of the claims that we process are for individual indemnity or limited payment contract.
- 28. Data matches to other organizations and insurers.**
- 29. Cost avoidance processing through review of external databases.**
- 30. Calculation of average savings to cost ratios to determine cost-effectiveness of TPL/COB activities.**
- 32. Other innovative strategies in other party liability.**

Strategies 28, 29, 30 and 32 are not applicable to the product mix for which claims are administered.

Topic/Area Four: Alternative Mechanisms for Payment to Providers

22. Payment mechanisms for hospitals.

- ① Make appropriate use of deductibles and co-pay, as contract language permits.
- ① Contact hospitals for all billings in excess of \$10,000 to negotiate discounts.
- ① During claim adjudication process, address situations where "unbundling" or "bundling" of charges would result in reduced costs.
- ① During monthly automated claim review process, identify any "bundling" or "unbundling" optimization situations that were overlooked during manual process; contact hospital to receive credit.

23. Payment mechanisms for providers

24. Payment for outpatient hospital services

- ① During claim adjudication process, address situations where "unbundling" or "bundling" of charges would result in reduced costs.
- ① During monthly automated claim review process, identify any "bundling" or "bundling" optimization situations that were overlooked during manual process. Contact to receive credit.

25. Payment mechanisms to encourage bulk purchasing.

26. Payment mechanisms to encourage quality improvement capacities of providers.

27. Other strategies in payment mechanisms

Strategies 25, 26 and 27 are not directly applicable to the products for which we administer claims.

Area/Topic Three: Utilization Management

17. Pre-and Post-Payment Claims Review

- ① During the claim adjudication process, the trained examiner reviews the charges to ensure claims are paid within the pre-defined contractual limits. System edits in the claim processing system pend any claims processed that exceeds pre-set limits and requires a supervisory review.
- ① During monthly automated claim review process, any charges in excess of local and/or regional usual and customary are flagged. This prompts a manual review and analysis to determine if overpayment credit will be sought or whether we have additional investigation to determine a potential claim abuse or fraud situation.

18. Internal Retrospective Review of accuracy of care provider decisions.

19. Drug Utilization Review to determine the accuracy/appropriateness of prescription medications.

20. Utilization Management Tracking to determine if strategies are effective and should be continued or modified.

- ① All claim examiners are trained on the typical care treatments for the specified disease and more comprehensive health products. On a case-by-case basis any questions as to appropriateness of care, care strategies or prescription drugs for the condition diagnosed is referred to an independent assessment firm comprised of physicians with medical specialties.

21. Innovative strategies in utilization management.

- ① We consider and implement any utilization management strategies appropriate to the health insurance contracts for which we administer claims.

12. Case Management

14. Concurrent Review to determine appropriateness of continued stay.

15. Discharge Planning

16. Outpatient Utilization Review

- ① A comprehensive array of methods are utilized under the general topic of Case Management. This includes assignment of active claims for those occurrences of catastrophic illnesses and injuries to specialists in case management. Individual assessment of these situations will be done with the healthcare providers and the insured. The goal is to target the most cost-effective appropriate level of care.
- ① Concurrent review, Discharge Planning review and Outpatient Utilization Review processes involves the same components utilized in Case Management. Whenever possible, we seek solutions that will speed the insured's discharge from a hospital to a supervised Home Health Care situation with skilled or semi-skilled care providers. Plans of care are jointly developed by the insured/patient, the physician, our Case Management specialist and our Claims Administration management team.

13. Pre-admission and admission review to hospital to determine appropriateness of admissions.

- ① Pre-admission/pre-certification is not required under our current individual specific disease products or our association trust health plans.

11. Provider profiling to determine utilization trends and service delivery patterns.

This strategy is not applicable for the products for which we administer claims.

Topic/Area Two: Quality Improvement and Assessment Strategies

10. Other innovative strategies in quality improvement and assessments.

- ① We have entered into a collaborative relationship with National Case Management Partnership. Their assessments, especially of the senior age segment of our customer population, seek to include many community-based and family-based services which reduce the overall cost of care while providing an improved social support system for our insureds.

6. Other innovative strategies for integrated health care delivery systems.

7. Contracting with providers with quality improvement and assessment in place.

8. Collection of data on efficiency, quality and patient demographics.

9. Use of provider profiling results in development of quality improvement and assessment features.

Strategies 6, 7, 8 and 9 are not directly applicable to the products for which we administer claims.

Topic/Area One: Integrated Systems for Health Care Delivery.

3. Flexible benefit plans that provide the most cost-effective services to meet patient's needs.

- ① Currently marketed senior-age products provide flexibility to utilize care at the level most appropriate to the need of the patient/insured. Specific disease policies by their nature do not have this flexibility.

4. Provider networks developed based on utilization, quality profiling and patient satisfaction.

5. Provider networks that promote cost-effectiveness.

- ① Through an affiliated company, we realize significant PPO discounts on member hospitals when accessed by insureds under our association trust contracts. This Preferred Provider Organization provides statistical analysis of utilization to participating providers.

1. Benefits packages that promote coordinated care.
2. Benefits packages that include health promotion and promote health education.

Strategies 1 and 2 are not directly applicable to the individual specific disease products currently marketed. However, new product design will consider appropriate incentives for health promotion to determine the effectiveness of these strategies as an overall cost management strategy.

Trustmark

INSURANCE COMPANY

400 Field Drive • Lake Forest, Illinois 60045
Phone 1 (800) 666-6977 • Fax (708) 615-3910

Tobi Weitzenfeld, FLMI, CLU
*Assistant Vice President
Contracts and Compliance*

April 18, 1994

Ms. Dorothy Bradley
Montana Health Care Authority
P O Box 200901
Helena MT 59620-0901

Dear Ms. Bradley:

Enclosed is our Company cost management data and plan.

Thank you for granting us an extension for making this filing based on the fact that we did not receive the request until just before the original due date.

Yours very truly,


Ms. Tobi Weitzenfeld

TW/lem

4-18 - 12

TOPIC 1:

Trustmark's integrated systems strategies consist of:

- lower rates for nonsmokers.
- encouraging the use of the most cost effective services by requiring certain surgical procedures being performed on an outpatient basis.
- providing benefits on alternative types of care such as home care services, nursing home services, hospice care services and out of hospital nursing care services.
- will offer an optional prescription drug card services to encourage purchasing through competitive pricing arrangements by late 1994.
- will offer an optional hospital PPO in late 1994.
- will offer a physical exam benefit in late 1994.

TOPIC 2:

Trustmark's Quality Improvement and assessment strategies consist of:

- collecting data on efficiency and quality from our PPO hospitals.

TOPIC 3:

Trustmark's utilization management strategies consist of:

- requiring precertification of all planned hospital admissions and certification of emergency admission to determine appropriateness of admissions. The system includes an appeal process in case of adverse decisions.
- utilizing voluntary case management intervention on both chronic and catastrophic illness to ensure appropriate utilization of health care resources and provide alternative health care settings to inpatient confinements.
- requiring certain surgical procedures must be performed on an outpatient basis unless physician provides documentation of need for inpatient stay. A penalty is applied to the claim if the surgery is not done on an outpatient basis.

- surveying patients to gather their satisfaction level with our claim service and customer service staff.
- tracking administrative claim cost levels on a monthly and annual basis.

TOPIC 7:

Trustmark's Anti Fraud Strategies include:

- ongoing training efforts of all claim personnel in the area of recognizing potential fraud.
- developing a special investigation unit to investigate suspected fraud or abusive cases.
- membership in a national health care anti fraud association and local area anti fraud networks.



RECEIVED

ULLICO Inc.
111 Massachusetts Ave., N.W.
Washington, DC 20001
202/682-0900

Victoria E. Fimea
Attorney
202/682-6687 Facsimile: 202/682-6784

Montana Health Care Authority

February 28, 1994

OVERNIGHT DELIVERY VIA UNITED PARCEL SERVICE

Montana Health Care Authority
28 North Last Chance Gulch
P.O. Box 200901
Helena, Montana 59620-0901

**RE: The Union Labor Life Insurance Company ("Union Labor Life")
Cost Management Plan (the "Plan")**

To the Authority:

In accordance with the Authority's memorandum dated 1/7/94 (received in our offices on 2/7/94) enclosed is a copy of Union Labor Life's Plan.

The Plan consists of four parts:

- Tab 1 - Case Management Policies & Procedures;
- Tab 2 - Preadmission Certification;
- Tab 3 - The Union Labor Life Insurance Company Managed Care Report; and
- Tab 4 - Health Insurer Data Sheet.

Any questions regarding the Plan may be directed to my attention.

Very truly yours,

Victoria E. Fimea

VEF:tmb
Enclosure

300075LegislationLettersPRO-94-026
LMT Health Care Authority re Cost Mgmt

RECEIVED

1994 2/1/1994

Montana Health Care Authority



The Union Labor Life Insurance Company
Cost Management Plan

filed
February 28, 1994
with the
Montana Health Care Authority

CASE MANAGEMENT POLICIES & PROCEDURES

CASE MANAGEMENT POLICIES AND PROCEDURES

DEFINITION: INDIVIDUAL CASE MANAGEMENT IS AN INNOVATIVE PROGRAM DESIGNED TO MANAGE THE COST OF CARE ASSOCIATED WITH CATASTROPHIC INJURY OR SERIOUS ILLNESS. THROUGH CASE MANAGEMENT, POTENTIALLY HIGH COST CASES ARE IDENTIFIED EARLY AND MONITORED ON AN INDIVIDUAL BASIS TO ENSURE THAT APPROPRIATE CARE IS PROVIDED IN THE MOST COST-EFFECTIVE SETTING.

THE PHYSICIAN IS RESPONSIBLE FOR PRESCRIBING THE PATIENT'S CARE. THE INDIVIDUAL CASE MANAGER COORDINATES AND MONITORS ALL SERVICES THAT MEET THE PATIENT'S NEEDS.

GROWING SOPHISTICATION IN HEALTH CARE COST CONTAINMENT HAS LEAD TO A NEW FOCUS FOR BENEFITS MANAGEMENT - THE HIGH COST PATIENT. HEALTH CARE USE AND COSTS ARE SPREAD UNEVENLY ACROSS THE POPULATION. ONLY A SMALL NUMBER OF CLIENTS RESULT IN A MAJOR PORTION OF THE BENEFITS PAID OUT.

ELEMENTS OF INDIVIDUAL CASE MANAGEMENT PROGRAM:

INDIVIDUAL CASE MANAGEMENT PROGRAMS (ALSO CALLED CATASTROPHIC CASE MANAGEMENT) ARE ORGANIZED EFFORTS TO IDENTIFY HIGH-COST CLIENTS AS EARLY AS POSSIBLE, ASSESS ALTERNATIVE TREATMENT OPTIONS, AND MANAGE HEALTH CARE BENEFITS FOR THESE CLIENTS AS EFFECTIVELY AS POSSIBLE.

THE GOALS OF THE PROGRAM ARE TO ASSURE THAT:

1. CARE IS PROVIDED IN THE MOST COST-EFFECTIVE SETTING.
2. TRANSFER TO A MORE APPROPRIATE SETTING TO MAXIMIZE THE OUTCOME OF THE TREATMENT PLAN.
3. QUALITY OF CARE IS NOT COMPROMISED AND QUALITY OF LIFE MAY BE ENHANCED.
4. BENEFITS THAT WOULD NOT OTHERWISE BE AVAILABLE MAY BE PROVIDED TO COVER CARE THAT WOULD LOWER COST OR PROVIDE MORE APPROPRIATE SERVICES.

CASE MANAGEMENT BEGINS WITH A REFERRAL FROM PREADMISSION REVIEW, UTILIZATION REVIEW, DISCHARGE PLANNING, THE FUND, CLAIMS, THE PHYSICIAN, OR THE CLIENT.

CASE MANGEMENT PROGRAM OBJECTIVES

1. TIMELY IDENTIFICATION OF POTENTIAL CASES.
2. ASSESSMENT OF CLIENT'S PHYSICAL, PSYCHOLOGICAL, AND SOCIAL NEEDS.
3. ASSESSMENT OF CLIENT'S FAMILY, COMMUNITY, INSTITUTIONAL, AND INDIVIDUAL SUPPORT SYSTEMS.
4. FORMULATE CARE PLAN WITH PHYSICIAN, FAMILY, CLIENT, SOCIAL SERVICES, AND PROVIDER INPUT.
5. MONITOR AND MODIFY PLAN OF CARE.
6. COORDINATION OF SERVICES WITH PROVIDERS.
7. OPTIMAL BENEFIT MANAGEMENT.
8. FACILITATING THE TEACHING OF CLIENT OR PRIMARY CARE GIVER TO AQUIRE SKILLS NEEDED TO ASSUME RESPONSIBILITY OF CARE.
9. MONITOR CLIENT'S PROGRESS AND EVALUATION OF THE CARE PLAN AT THE CASE CLOSURE.

SCOPE OF CASE MANAGEMENT

CANDIDATES:

1. MUST HAVE PRIMARY COVERAGE THROUGH A CARRIER WITH AN AGREEMENT FOR CASE MANAGEMENT AND MEET THE SELECTION CRITERIA;
2. THE CLIENT MUST HAVE BENEFITS AVAILABLE;
3. THE CLIENT MAY BE IN ANY SETTING;
4. IF THE CLIENT HAS OTHER PRIMARY COVERAGE, THE BENEFITS MUST BE EXHAUSTED OR DO NOT EXIST FOR THE SERVICES REQUIRED;
5. THE CLIENT, LEGAL GUARDIAN, OR FAMILY AND THEIR PRIMARY PHYSICIAN MUST CONSIDER AND CONSENT TO THE UTILIZATION OF AN ALTERNATIVE TREATMENT PLAN;

- On the anticipated date of discharge of an authorized stay, the NR or the ULLICARE™ clerk contacts the hospital to find out if the patient has been discharged.
- If the patient has been discharged, the discharge information is completed in the system (Exhibit PAC 6). The hard copy file is stored according to policy number in locked file drawers.
- If the patient has not been discharged the Continued Stay Review Process is initiated and continued until the patient is discharged.

4.2 URGENT OR EMERGENCY ADMISSIONS

- 4.2.1** Urgent or Emergency Admission - one which results from bodily injury or medical condition arising suddenly and requiring immediate care.
- 4.2.2** Notification of the admission is to occur within 72 hours, however the NR does consider the circumstances involved if notification is after that time period. Each case is reviewed on an individual basis to determine the appropriateness of the admission.
- 4.2.3** If the admission is appropriate, the PAC process is the same as in an elective admission described in Section 3.1.2, but the type of admission is coded as urgent or emergency.

4.2.4 If insufficient information is available to make a determination, the case is referred to the PA or medical records may be requested.

4.3 Maternity Admissions

4.3.1 A maternity admission is entered into the ULLICARE™ system as soon as ULLICARE™ is notified. (This may be up to 7 - 8 months in advance.)

4.3.2 Eligibility is checked for the current period. If the patient is eligible, letters are generated and sent the next day.

4.3.3 A maternity stamp that reads the following:

ULLICARE™ ALLOWS 4 DAYS FOR A C-SECTION. THIS CERTIFICATION IS PENDING ELIGIBILITY AT TIME OF ADMISSION. PLEASE NOTIFY ULLICARE™ WHEN THE PATIENT IS ADMITTED.

is placed on every letter sent out for an upcoming maternity admission.

4.3.4 The Nurse Reviewer asks the patient to call ULLICARE™ with her actual date of admission. The chart is then filed for follow-up 2 weeks following the due date.

4.3.5 If you can determine initially that we are the secondary carrier of a patient, you only need to enter the initial Patient Detail screen. (On this screen the only required fields are the name fields, and the sex fields.) Then on the COB line enter ULLICO secondary, initials and date.

DRG Notes:

If a patient is admitted to a DRG state, a Y is entered into the DRG field. Using our DRG listings, a WDRG code is added to the WDRG field. In the treatment plan, the NR enters the outlier days. In New York the DRG begins on the day of admission, regardless of the trimpoints, they would then become an outlier on the High trimpoint. We can therefore disregard the low trimpoint in NY. In NJ they do operate on both high and low trimpoints.

In NY, the NR follows the patient and continues to send both PAC & CSR letters. In NJ initial PAC letters are sent, CSR letters are not sent.

If a patient stays over the high trimpoint in either state, the case is referred to the PA for approval.

6.0 CONTINUED STAY REVIEW

During hospitalization the patient's progress is monitored on an on-going basis to assess changes in their medical condition that would necessitate an extended hospital stay.

6.1 Process

- When the patient remains in the hospital at the time that the initially approved LOS expires, the NR contacts the physician, or his agent, to determine the reason for the continued stay. The NR enters the clinical information and treatment plan into the system (Exhibit CSR 1).
- If the patient meets the criteria for continued acute hospitalization an additional number of days are authorized. A PAC Letter #116 (Exhibit CSR 2) is sent to the member, physician, hospital and claims office.
- The CSR process continues as long as the patient remains hospitalized. The NR documents clinical information each time a review is performed and a PAC Letter #116 is sent after each review.
- As with all reviews, if the NR is unable to authorize the continued stay, the case is referred to the PA.
- If the PA needs further clinical information to make a decision, he/she contacts the attending physician to discuss the case. If the PA and attending physician reach an agreement, PAC Letter #116 is sent to all concerned parties.

- If the PA and attending physician cannot reach an agreement, the process will be the same as previously described in 3.1.2.
- If the decision is to not authorize the continued stay, the physician, patient or responsible party, hospital and claims office are notified by telephone and a PAC Letter #118 (Exhibit CSR 3) is sent by overnight mail to the member with copies to the physician, hospital and claims office. The written notification indicates the date beyond which the stay is not authorized and outlines the procedure for a reconsideration of the decision.
- If the continued stay is not authorized, ULLICARE™ will take into consideration the need to finalize discharge plans and may authorize a reasonable amount of time for this purpose.
- Once the patient is discharged, the NR completes the discharge information in the system and files the hard copy as previously described in Section 3.1.2.
- If you had entered an incomplete CSR for another nurse, and it remains incomplete with your initials for more than one week bring it to the primary nurses attention, and change the initials on the PAC or CSR.
- All CSR's are expected to be completed within 24 to 48 hours of the anticipated discharge date.

THE UNION LABOR LIFE INSURANCE COMPANY
ATTENTION: ULLICARE
11 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20001



COST MANAGEMENT PROGRAMS

Toll Free 800/848-9200

Local No. 202/682-6961

PREADMISSION CERTIFICATION - ALL DAYS APPROVED

DATE

SSN: _____
PATIENT: _____
PLAN: _____
ADMISSION DATE: _____
REFERENCE NO: _____

Dear DR. NAME:

Based on the information presented to us at the time of notification, the admission on the above-named patient to HOSPITAL NAME on ADMISSION DATE has been authorized for an initial length of stay of # OF DAY(S). This admission will be processed according to plan benefits, limitations, and exclusions.

If on ANTICIPATED DISCHARGE DATE, PATIENT NAME remains hospitalized, we will contact you to obtain information necessary to establish criteria for continued hospitalization.

This authorization does not confirm or verify eligibility for health benefits nor is it a guarantee or representation that coverage or benefits will be in effect for health care services rendered during this hospitalization.

Thank you for your cooperation in our Utilization Management Program. Please call us if you have any questions.

Sincerely,

Nurse Reviewer Name
Utilization Management program

cc: Member
Hospital
Group



THE UNION LABOR LIFE INSURANCE COMPANY
ATTENTION: ULLICARE
111 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20001



COST MANAGEMENT PROGRAMS

Toll Free 800/848-9200

Local No. 202/682-6961

CONTINUED STAY REVIEW - APPROVED

DATE

SSN: _____
PATIENT: _____
PLAN: _____
ADMISSION DATE: _____
REFERENCE NO: _____

Dear DR. NAME:

Based on the information presented to us at this time regarding the confinement of PATIENT NAME, we have authorized an additional length of stay of 4 DAYS days. This admission will be processed according to plan benefits, limitations and exclusions.

If on ANTICIPATED DISCHARGE DATE, PATIENT NAME, remains hospitalized, we will contact you to obtain information necessary to establish criteria for continued hospitalization.

This authorization does not confirm or verify eligibility for health benefits nor is it a guarantee or representation that coverage or benefits will be in effect for health care services rendered during this hospitalization.

Thank you for participating in our Utilization Management Program. Please call us if you have any questions.

Sincerely,

NR NAME
Nurse Reviewer
Utilization Management Program

cc: Member
Hospital
Group



THE UNION LABOR LIFE INSURANCE COMPANY
ATTENTION: ULLICARE
1 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20001

ULLICARE

COST MANAGEMENT PROGRAMS

Toll Free 800/848-9200

Local No. 202/682-6961

PREADMISSION CERTIFICATION - APPROVED: PREOP DAY NOT APPROVED

DATE

SSN: _____
PATIENT: _____
PLAN: _____
ADMISSION DATE: _____
REFERENCE NO: _____

Dear DR. NAME:

Based on the information presented to ULLICARE™ at the time of notification, the admission on the above-named patient to HOSPITAL NAME on ADMISSION DATE has been authorized for an initial length of stay of # OF DAYS day(s). Please note that the PREOPERATIVE DATE, a pre-operative day is not authorized as the services as recommended can be processed according to policy benefits, limitations and exclusions.

If on ANTICIPATED DISCHARGE DATE, PATIENT NAME remains hospitalized, ULLICARE™ will contact you to obtain information necessary for continued hospitalization.

Remember only you and your patient can make decisions regarding his medical care. If you elect to be hospitalized for pre-operative testing, benefits for services rendered, including room and board charges, will be considered in accordance with the policy's benefits, limitations and exclusions.

If you wish ULLICARE™ to reconsider its decision, you may request this in writing to:

ULLICARE™
The Union Labor Life Insurance Company
111 Massachusetts Avenue, N.W.
Washington, D.C. 20001

Attention: Jane Gruenebaum, RN, Manager, ULLICARE™



This authorization does not confirm or verify eligibility for health benefits nor is it a guarantee or representation that coverage or benefits will be in effect for health care services rendered during this hospitalization.

Sincerely,

Jane Gruenebaum, RN
Manager
Hospital Certification Program

cc: Member
Hospital
Group

THE UNION LABOR LIFE INSURANCE COMPANY
ATTENTION: ULLICARE
11 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20001



COST MANAGEMENT PROGRAMS

PREADMISSION CERTIFICATION - DENIED

Toll Free 800/848-9200

Local No. 202/682-6961

DATE

SSN: _____
PATIENT: _____
PLAN: _____
ADMISSION DATE: _____
REFERENCE NO: _____

Dear DR. NAME:

After careful review of the available information presented to ULLICARE™ at the time of notification, we are unable to authorize the admission of the Above-named patient to HOSPITAL NAME on ADMISSION DATE. The services as recommended can be reasonably performed in an alternative setting, such as on an outpatient basis, skilled nursing facility, etc.

If you wish ULLICARE™ to reconsider its decision, you may request this in writing to:

ULLICARE™
The Union Labor Life Insurance Company
111 Massachusetts Avenue, N.W.
Washington, D.C. 20001
Attention: Jane Gruenebaum, RN, Manager, ULLICARE™

Remember only you and your patient can make decisions regarding his medical care. Should the patient elect to receive services on an inpatient basis, benefits for services rendered, will be considered in accordance with the policy's benefits, limitations and exclusions.

Thank you for participating in ULLICARE™'s Utilization Management Program. Please call us if you have any questions.

Sincerely,

Jane Gruenebaum, RN
Manager
ULLICARE™ Utilization Management Program

cc: Member
Hospital
Group

THE UNION LABOR LIFE INSURANCE COMPANY
ATTENTION: ULLICARE
111 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20001



COST MANAGEMENT PROGRAMS

Toll Free 800/848-9200

Local No. 202/682-6961

CONTINUED STAY REVIEW - NOT APPROVED

DATE

SSN: _____
PATIENT: _____
PLAN: _____
ADMISSION DATE: _____
REFERENCE NO: _____

Dear DR. NAME:

Based on the information presented to ULLICARE™ at this time regarding the confinement of PATIENT NAME, we are unable to authorize an additional length of stay beyond the ANTICIPATED DISCHARGE DATE. Based on our review, the services as recommended can be reasonably performed in an alternative setting, such as on an outpatient basis, in a skilled nursing facility, etc.

If you wish ULLICARE™ to reconsider its decision, you may request this in writing to:

ULLICARE™
The Union Labor Life Insurance Company
111 Massachusetts Avenue, N.W.
Washington, D.C. 20001
Attention: Jane Gruenebaum, RN, Manager, ULLICARE™

Remember only you and your patient can make decisions regarding his medical care. Should the patient elect to receive services on an inpatient basis, benefits for services rendered, will be considered in accordance with the policy's benefits, limitations and exclusions.

Thank you for participating in ULLICARE™'s Utilization Management Program. Please call us if you have any questions.

Sincerely,

Jane Gruenebaum, RN
Manager
ULLICARE™ Utilization Management Program



LIST OF SURGICAL PROCEDURES THAT REQUIRE A MANDATORY SECOND SURGICAL OPINION

Procedure:

Cataract	Removal of Lens from Eye
Cholecystectomy	Removal of Gall Bladder
Bunionectomy	
Repair of Hammer Toes	Operation on the Foot or Toes
Coronary Artery Bypass Graft	
Angioplasty	
Carotidendarterectomy	Operation on the Heart
Hemorrhoidectomy	Removal of Hemorrhoids
Herniorrhaphy	Repair of Inguinal, Femoral, Ventral or Incisional Hernia
Hysterectomy	Removal of Uterus
Arthroscopic Surgery	
Arthroplasty	Operation on the Knee
Laminectomy	
Diskectomy	Removal of Intervertebral Disc of Spine
Ligation and Stripping of Varicose Veins	Removal and tying of Varicose Veins
Mastectomy	Partial Complete Removal of Breast
Transurethral Resection	
Prostatectomy	Removal of Prostate
Submucous Resection	"
Septoplasty	Operation on the Nose
Tonsillectomy and/or Adenoideectomy	Removal of Tonsils and/or Adenoids

If you have any questions as to whether a specific surgical procedure is considered elective, you may contact the Second Surgical Opinion Unit By Calling toll-free 800-848-9200.

Question # 5 Responses:

Pre-authorization (include list of procedures)

ULLICARE does not perform pre-authorization review based on a list of procedures; all hospital admissions are reviewed.

Concurrent review (include description of criteria and any forms used)

ULLICARE utilizes InterQual Criteria.

Retrospective review (include description of criteria and any forms used)

Utilizing the same criteria, retrospective review is performed if the patient has already been discharged at the time for notification or if ULLICARE is unable to obtain the medical information during hospitalization. Medical records may be requested.

Second surgical opinion (include list of procedures)

List Attached

Readmission review (include description of criteria used)

All hospital admissions are reviewed (scheduled, urgent, emergency and readmissions) and utilize Interqual Criteria.

9.0 RECONSIDERATION PROCESS

ULLICARE™ has responsibility for addressing reconsiderations that are related to decisions made as part of the Hospital Utilization Review Programs.

- 9.1** If the admission or any portion of the stay are not authorized, the patient, hospital, attending physician, claims office and/or Client are notified by phone and letter of **ULLICARE™'s** decision. The letter will outline the procedure for requesting a reconsideration of the decision, including the submission of any additional medical information/records.
- 9.2** When a written request for a reconsideration is received, the case would be referred to a Board Certified Specialist, not previously involved with the case
- 9.3** **ULLICARE™** will respond to a written reconsideration within 2 working days if the patient is still hospitalized and 30 working days if the patient has been discharged. All concerned parties are notified in writing of **ULLICARE™'s** decision.
- 9.4** If **ULLICARE™'s** original decision is upheld, the member/patient may have additional appeal rights through the Client.

13.3 Telephone Standards

ULLICARE™ has established the following telephone standards that are nationally recognized standards for providing efficient services to our Clients.

- 90% of all calls will be answered in 30 seconds.
- Average speed of answer will be 10 seconds.
- The number of abandoned calls will be less than 10%.
- The Voice Mail will be checked for messages every 1/2 hour throughout the working day.
- All messages received during working hours will be returned within 2 hours of the time the call was received.
- All messages received after the close of business and on weekends and holidays will be returned within the first 4 hours of the next business day.
- ULLICARE™'s hours of operation are 8 a.m. - 6 p.m. Eastern Time Monday through Friday, except holidays.
- After normal business hours and on weekends, callers will receive a recorded message that instructs them to leave their name and phone number, not to delay treatment in an emergency situation and ULLICARE™ will return their call on the next business day.

11.0 CONFIDENTIALITY

ULLICARE™ is committed to protecting the privacy rights of the patient and maintaining confidentiality of patient data.

11.1 Confidentiality of data is safeguarded by the following methods:

- Computer access by only authorized personnel with control through Centralized Information Management System.
- IMS security training for all new personnel.
- Passwords known only to individual user and IMS Security personnel with mandated changes authorized every 30 days.
- The Cost Management System is a free-standing data base which interacts with the claims system. Its design safeguards the integrity of on-line documentation - edits prevent change of certain data, other changes are permitted only by supervisor's password.
- System demonstrations are conducted using dummy files and conducted in an area away from the daily operation of the programs.
- Periodic in-service educational presentations provide on-going feedback regarding the proper documentation requirements as compared with our random quality assurance reviews.
- All medical records are secured under separate lock and key.

- The Nurse Reviewer locks all of her on-going cases in her desk drawer each evening.

Remember! You must use this program anytime that your doctor recommends a hospital admission for you or a covered dependent.

HOSPITAL REVIEW PROGRAM

Hospital Review Program

The Union Labor Life Insurance Company

CALL TOLL FREE

800-848-9200

ULLICOcare

ULLICO'S COST MANAGEMENT PROGRAM

Why Is a Hospital Pre-Admission Certification Program necessary?

Costs for health care have escalated in the last decade and the national average is now between \$2,000 and \$3,000 per person annually. The majority of these expenses pay for services in the hospital.

ULLICARE believes that it is important that you continue to be able to obtain hospital care, when necessary, without compromising the quality of that care. By assuring you that a hospitalization is necessary and that your hospital stay is not prolonged beyond the time medically required, you will also be helping to keep down the rising cost of your health care.

What Is Hospital Pre-Admission Certification (PAC)?

Hospital Pre-Admission Certification (PAC) requires you to have your proposed hospital stay reviewed by ULLICARE'S professional staff prior to your hospital admission. Based on information provided by your doctor, ULLICARE will determine whether your hospitalization is medically necessary or if the treatment might be provided in a different setting. At the same time they will assign an initial number of approved hospital days and notify you, your physician and the hospital.

What happens if I need more hospital days than were initially approved?

When the initially approved hospital days are up, ULLICARE will contact your doctor to learn if you will be discharged or if your physician feels that an extension of your hospitalization is required. If the ULLICARE reviewers agree, additional days will be approved.

What should I do when my doctor recommends admission to a hospital for either myself or an eligible dependent?

You must call ULLICARE immediately (Toll Free) at 800-848-9200 between the hours of 8 a.m. and 6 p.m. EST Monday through Friday. Be sure to have the following information on hand: the name and social security number of the employee, the name and policy number of the fund, the name and phone number of your doctor, the name of the hospital where you will be treated, the date you are planning to enter the hospital, and the planned surgical or diagnostic procedure.

If you call after normal business hours, you will receive a recorded message instructing you to leave your name and phone number and your call will be returned on the next business day.

What about urgent or emergency hospital admissions where there is not time to go through the Precertification process?

When you require an URGENT admission your doctor should telephone ULLICARE at 800-848-9200 and give them the information so that they can assign an initial approved number of hospital days.

When you are hospitalized for an EMERGENCY, the doctor or a responsible family member must call ULLICARE within 72 hours to notify them of the hospital admission.

What happens if I do not use the Hospital Pre-Admission Certification Program?

You will receive maximum benefits if you use the program.

If you do not use the program, one of the following outcomes will occur:

- (1) If the admission would have been approved by ULLICARE as medically necessary, you will be subject to a \$_____ benefit reduction.
- (2) Any admission that would not have been approved as medically necessary by ULLICARE, will not be a covered expense and you will be responsible for 100% of the non-covered charges.

What Is Large Case Management?

ULLICARE will also provide a special service designed to assist patients with serious illnesses or injuries. Many people who have used this kind of service have found that it provides valuable assistance and peace of mind during difficult periods of serious illness. Serious medical cases include:

- Chronic illness; es
- Acute catastrophic injury
- Infectious disease
- Burns
- Terminal illnesses
- Neonatal complications
- AIDS and AIDS-related cases

A case management coordinator will contact you and your family to discuss your medical care needs. Your personal case management coordinator will help you by:

- Facilitating all activities and communication among the professionals involved in your treatment plan
- Providing information about your treatment options
- Identifying any needed additional medical resources that may be available to you

You are encouraged to take advantage of this valuable case management service. However, the choice is yours: participation is voluntary.

4.0 PREADMISSION CERTIFICATION PROGRAM

Preadmission Certification is a procedure that allows evaluation of a planned inpatient stay before admission, or in the case of an emergency or urgent admission, after admission. It provides ULLICARE™ an opportunity to review a hospital stay to determine if inpatient care is medically necessary.

4.1 Elective Admissions

To initiate the Preadmission Certification (PAC) process, it is the responsibility of the patient, the insured or a responsible family member to call the ULLICARE™ toll-free 800 number. However, to prevent an adverse effect on the patient's benefits, we accept notification by the physician, the physician's office or the hospital. A large number of PACs are initiated by the hospital because when checking on the patient's eligibility, they are informed that a PAC is required.

When an elective admission is scheduled, notification and the PAC process are to be initiated prior to the admission. This allows the ULLICARE™ staff the opportunity to review the need for the admission before it occurs and to determine an appropriate initial length of stay if the need for admission is evident.

If a patient is admitted on an urgent or emergency basis, ULLICARE™ is to be notified within 72 hours of the admission. After 6:00 PM Eastern Time on weekdays and on weekends and holidays, incoming calls, are recorded on ULLICARE™'s Voice Mailbox. Such calls are returned on the next business day (refer to section 10.0).

Elective Admission - one which the patient may delay without undue risk to their health.

If ULLICARE™ is notified of an emergency admission after the 72 hours, and the patient is still hospitalized, the NR will take all of the precertification information and monitor the hospital stay. The NR will attempt to obtain information to certify the initial portion of the hospital stay, or we will obtain medical records.

If ULLICARE™ is notified of an elective admission, after admission, and the patient remains hospitalized, the NR will take all of the precertification information and monitor the stay. The application of the penalty is at the discretion of the claims office.

If ULLICARE™ is notified of an admission following the patient's discharge, the NR will enter the precertification information into the system under a "not reviewed" status. The application of the penalty will be at the discretion of the claims office. At the request of the claims office, ULLICARE™ will review the medical records for appropriateness.

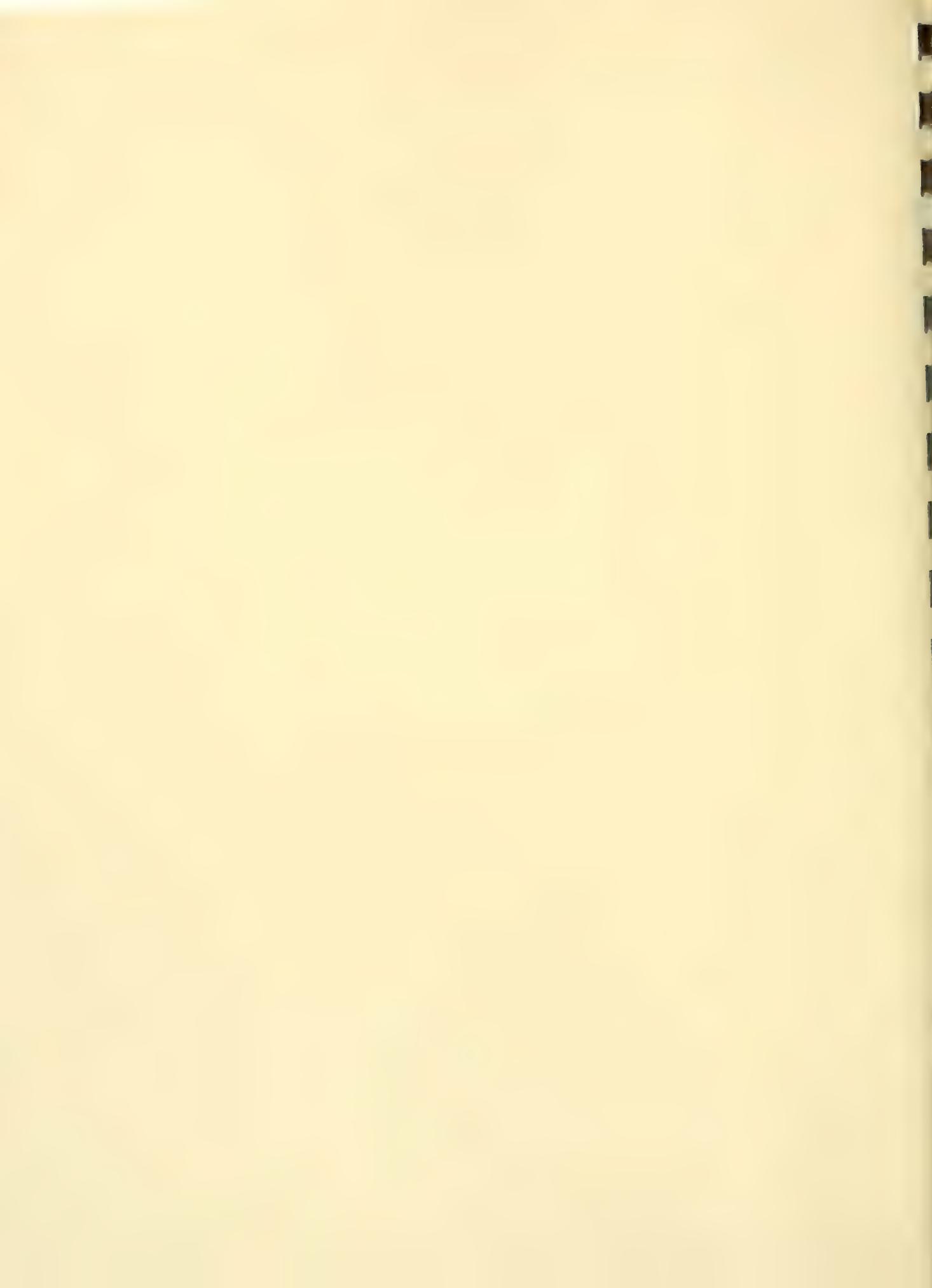
4.1.2 Process

- The Nurse Reviewer (NR) enters the initial demographic information, hospital and physician information, date of admission and admitting diagnosis. (Exhibit PAC 1).
- A reference number is generated once the information is entered into the system. This number is given to the caller as verification that the call has been received and a file initiated.

- Before proceeding, the NR checks eligibility to determine if the patient is eligible for benefits. If the patient is not eligible, the NR does not proceed further (refer to section 8.0).
- The NR contacts the attending physician or his/her designee to obtain the patient's diagnosis, clinical information, proposed treatment plan, reason why patient requires inpatient hospitalization and number of hospital days required. This information is entered into the system and remains strictly objective.
- In some cases the NR may contact the Utilization Review Department of the hospital to obtain the above information.
- Utilizing Inter Qual Criteria the NR reviews the clinical information and if criteria is met, the admission is authorized and an initial Length of Stay (LOS) is assigned. The 50th percentile Western region PAS length of stay data is used as a guideline when assigning a LOS. (If the patient is having a surgery, the PAS for the procedure is used. If the patient is not have a procedure, the PAS for the diagnosis is used.) A PAC Letter #115 (Exhibit PAC 2) is sent to the physician, member, hospital and claims office.
- The NR will authorize the admission and assign a LOS or refer the case to a

Physician Advisor (PA) within 24 hours of obtaining the information.

- If the clinical information or requested LOS does not meet the criteria, the NR complete a PA Referral Form (Exhibit PAC 3) and refers the case to the PA.
- The NR discusses the case with the PA - based on the information available, the PA may determine that the admission or LOS are appropriate. If further information is needed, the PA contacts the attending physician by phone to discuss the case. Generally, agreement is reached through the physician to physician review and the stay is authorized.
- If the PA and attending physician do not reach an agreement the PA will contact an appropriate Board Certified Specialist (in the medical or surgical area under consideration), to review the case. The decision will then be made as to whether to authorize or not authorize the admission. The physician, patient or responsible party, hospital and claims office are notified by telephone and a PAC Letter # 115 (Exhibit PAC 2), PAC Letter #119 (Exhibit PAC 4) or PAC Letter #117 (Exhibit PAC 5) is sent to each person. The final decision as to whether the patient is admitted is that of the patient and the attending physician.





Universe Life

The Universe Life Insurance Company
One Lewis Clark Plaza
P.O. Box 538
Lewiston, ID 83501-0538
(208) 799-9000 FAX (208) 746-8159

ENCLOSURE

CC:

March 16, 1994

Mr. Mike Craig
Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

RE: The Universe Life Insurance Company Cost Management Plan

Dear Mr Craig:

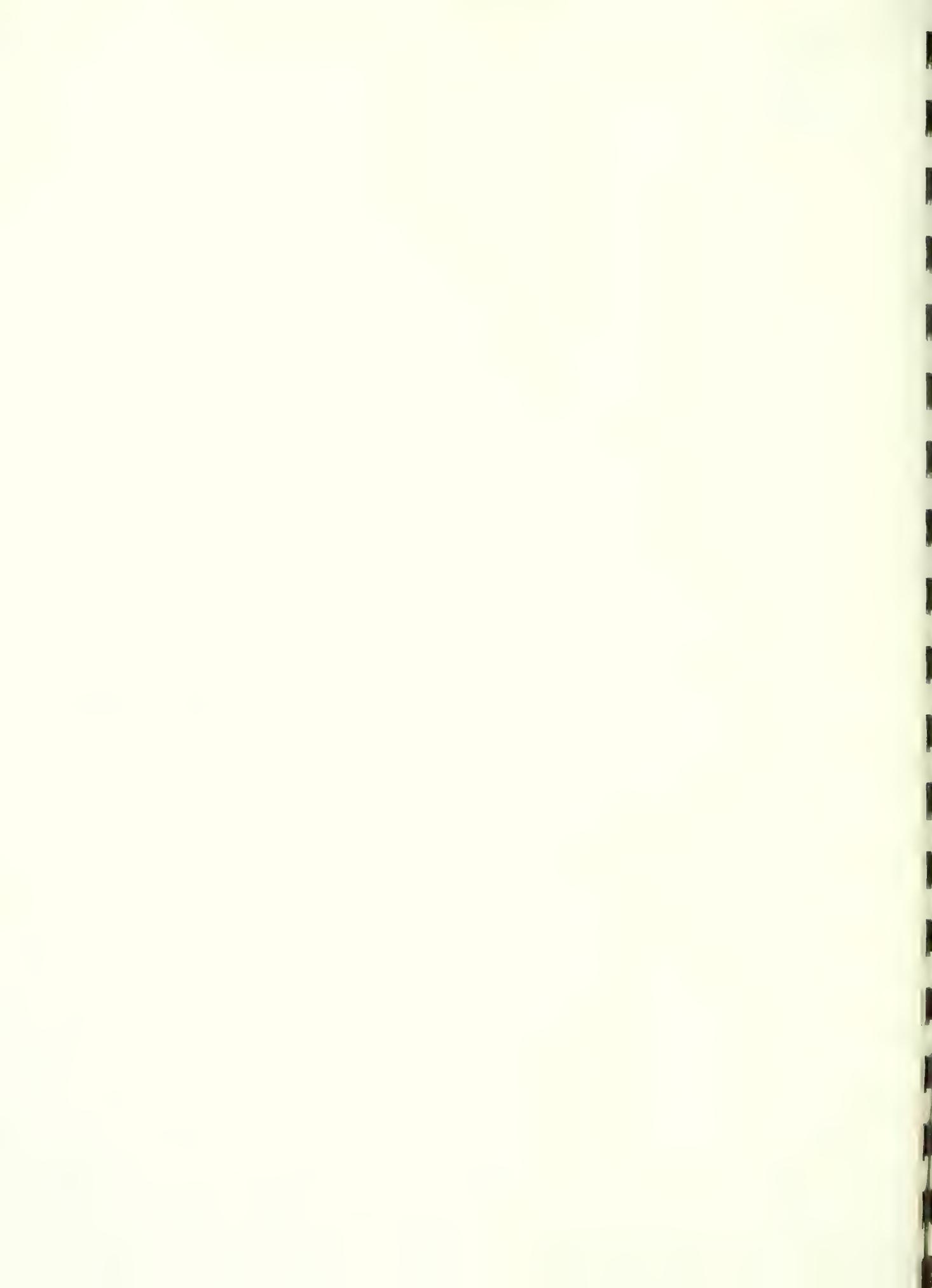
You decided on February 28 to extend the deadline for the Cost Management Plan to March 18, since we did not receive the specification until February 22. Also, the plan specifications were mailed to AIA Insurance, Inc., the group's third party administrator. The insuring company in the state of Montana is The Universe Life Insurance Company. Please update your files.

Enclosed please find the Cost Management Plan for The Universe Life Insurance Company. We addressed the areas of cost management that pertain to our claims management system. Two data sheets are provided with the management plan. One contains information concerning our Group Major Medical and the other our Individual Major Medical. Please note that the Individual block of business is quite small.

If any other information is required, my address is P.O. Box 538 Lewiston Idaho.

Sincerely,

Jay Taylor
Contract Analyst, HIA

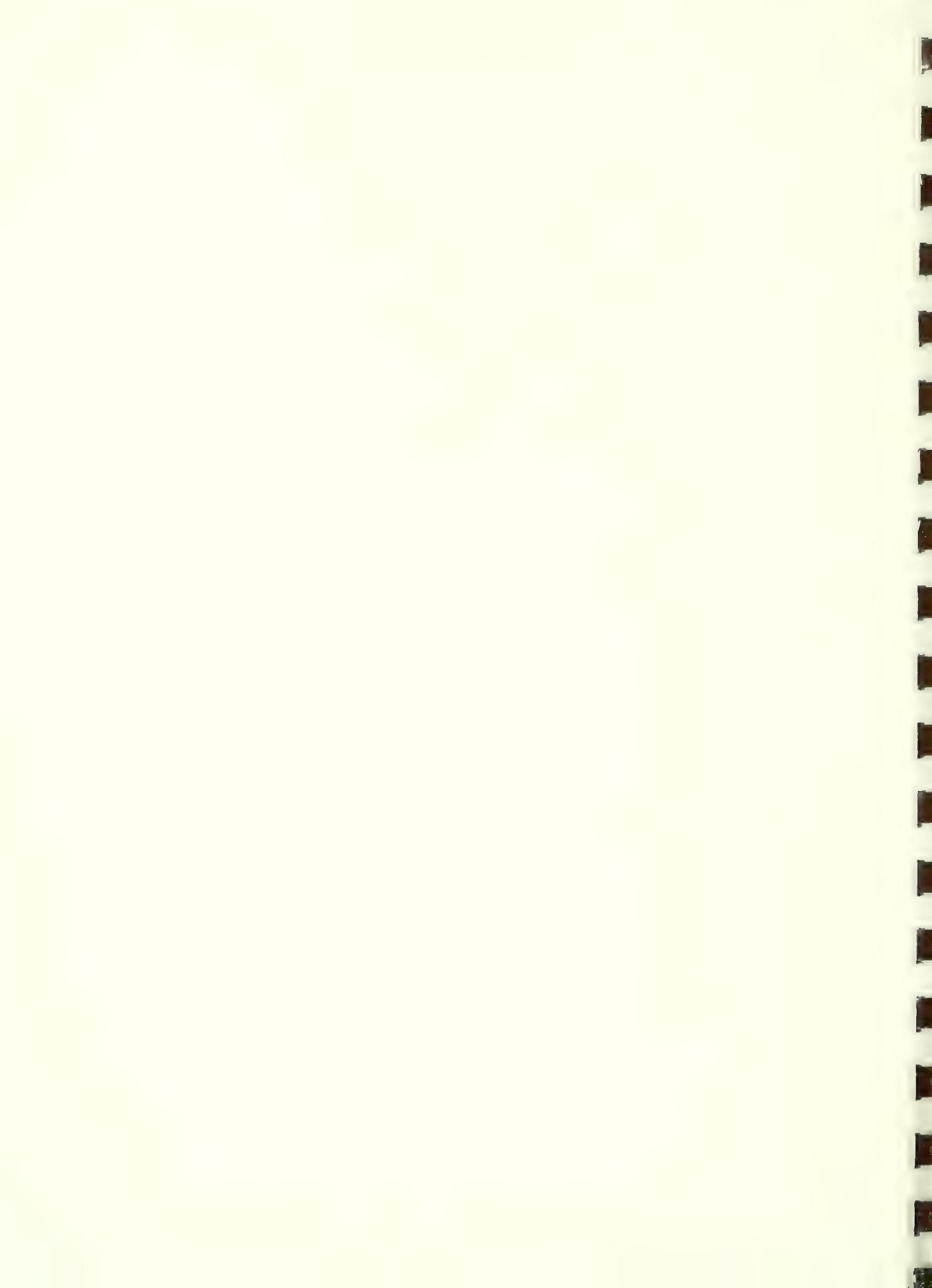


The Universe Life Insurance Company

COST MANAGEMENT PLAN

For the Montana Market

March 15, 1994



AREA ONE - Integrated Systems for Health Care Delivery Strategies

2. Benefit designs to promote healthy lifestyles and promote health education
- Premium discount for insureds that do not use tobacco.
 - The management program described below is designed to help educate our insureds in order to lower future medical costs relating to diabetes.
- Diabetic Self-Management Education Program defined as a program that:
1. primarily provides instruction to help diabetic patients in gaining an understanding of;
 - a. the diabetic disease process; and
 - b. the daily management of diabetic therapy;
 2. is provided by health care professionals under the direction of a licensed Physician;
 3. meets all licensing and certification requirements of the state and locality in which it is conducted; and
 4. meets any standards set by the American Diabetes Association.
3. Benefit designs to provide cost-effective services that meet a patient's needs
- Coverage in extended-care facilities, home health care, and hospice care are included as covered medical expense. These types of benefits create an option for the insured to receive care in more appropriate settings than in a hospital.
- Charges for the home health care services and supplies shown below furnished by a home health care agency:
 1. Part-time or intermittent home health care services by or under the supervision of a nurse;
 2. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
 3. Physical, occupational, speech, and respiratory therapy;
 4. Medical supplies, drugs, and medications prescribed by a physician;
 5. Laboratory services by or on behalf of a hospital;
 6. Nutritional counseling provided by or under the supervision of a registered dietician;
 7. Medical social services for a covered person who is diagnosed as terminally ill;
 8. The evaluation of the need for and development of the home health care plan.

Home health care benefits will be provided for up to 130 visits in any calendar year. Up to 4 consecutive hours of home health aide services in a 24-hour period will be considered one home care visit.

- Hospice Care Additional Covered Charges - Benefits are also payable for the following covered charges. These are added with respect to hospice care and services only:
 1. Charges for emotional support and counseling services for the family unit prior to the death of the terminally ill patient. Payment will not exceed \$25 for each counseling session. There is a limit of 12 such sessions per terminally ill patient.
 2. Charges for bereavement services provided in counseling sessions with the family unit during the six months following the death of the terminally ill patient. Payment will not exceed \$25 for each counseling session. There is a limit of 12 such sessions per terminally ill patient.
- Posthospitalization extended care facility coverage is included for up to 31 days per calendar year.

AREA THREE - Utilization Management

21. Innovative group policy features to reduce over-utilization and to control costs.

The policy includes an automatic deductible increase (ADI) that is optional to each certificate holder. A company benefit is allocated to each certificate holder to help pay the higher deductibles. Benefit amounts that are not used for deductible reimbursement can be used to pay premium increases and/or is available in cash over time.

This feature encourages consumers to spend health care dollars wisely. Substantial amounts of company benefit may be available for unlimited consumer use if the medical benefits have not been over-utilized. The majority of our certificate holders treat the available benefit as if it were their money. Insureds tend to spend their own money more efficiently than insurance company money.

12. Case Management to ensure appropriate utilization of health care resources.

- The Universe Life Insurance Company currently utilizes Professional Rehabilitation Management (PRM), Crawford & Company, and Atlantic Institute. Crawford & Company and PRM are contacted when we become aware of catastrophic illness or injury. Crawford and PRM initially do an on-site interview with the patient and family if appropriate. The primary focus of case management provides us with medical records, current status of the patient, and appropriateness of services being utilized and evaluates durable medical equipment needs.

Case management interventions result in cost reduction/containment. Cost reduction/containment is attained through negotiating discounts for inpatient rehabilitation treatment, durable medical equipment, chemotherapy drugs, and other interventions as appropriate. Case management many times allows us to determine whether purchase of durable medical equipment or rental is the most cost effective.

Case management is also utilized to assist in the determination of the appropriateness of Independent Medical Evaluations. Case personnel are able to meet with the insured, review medical records, and consult with physicians.

Atlantic Institute is utilized for insureds that are deemed possible transplant candidates. Atlantic Institute procures medical records and has them evaluated by a transplant physician. Atlantic also negotiates discounts for medical services. By utilizing these services, the groundwork is laid for the potential transplant recipient, preventing unnecessary delays that result when providers require "preauthorization."

- The Universe Life Insurance Company utilizes Medical Review Institute (MRI) and Robert J. Smith, M.D., to evaluate claims for appropriateness of services utilized. These services are commonly accessed to determine over-utilization, usual and customary fee determination, medical necessity issues, appropriateness of treatment being utilized, and determination of rider-related conditions. By utilizing outside independent reviewers, we are assured that claims are reviewed by a peer consultant and are fairly and accurately reviewed.

15. Discharge planning to determine the appropriateness of hospital discharge.

Whenever possible, a case management representative would start assisting in coordinating appropriate services for patient's discharge.

AREA FOUR - Alternative Payment Mechanisms to Providers

27. The Universe Life Insurance Company contracts with Medical Data Research (MDR), which uses Medical Usual Customary Reasonable Payment System in order to determine reasonable and customary allowable charges based on actual claims data for the widest range of medical service codes available in the industry.

Medical Data Research gathers a substantial amount of claim and fee schedule information from insurance companies, Blues Cross organizations, and government insurance carriers throughout the United States. By understanding both the nature of medical procedures and the evolution of claims payment system, MDR has been able to develop a superior method for analyzing and reporting UCR data.

The RVS methodology values medical procedures relative to each other on a scale in terms of difficulty, work, risk, and the material costs of the procedure. With the new medicare venture (RDRVS), there has been a great deal of renewed interest in relative value scales. Typically, a single dollar conversion factor is used to convert a side range of procedures to charges or allowables. Actual claims data is used to develop geographic-specific conversion factors used in UCR Payment Systems. Medical Data Research collects claims data for statistical analysis principally through a data contribution program from MDR's payer clients. This information is augmented by data collected directly from large clinics and physician billing organizations, Worker's Compensation, CHAMPUS carriers, and the Health Care

- .Financing Administration. The government information is not used to set prevailings directly.
22. Medical Data Research also maintains an active support department that provides expert guidance on coding and reimbursement issues that affect health claims payment. An operative report review service assists payers on complex claims. This would include identify unbundled claims that should be bundled.

AREA FIVE - Third Party Liability/Coordination of Benefits Strategies

31. Coordination of benefits.

The NAIC model is followed in order to assure nonduplication of benefits.

32. Other strategies.

The Company will subrogate in appropriate third-party liability situation. Contractual rights are retained.

AREA SIX - Administrative Methods

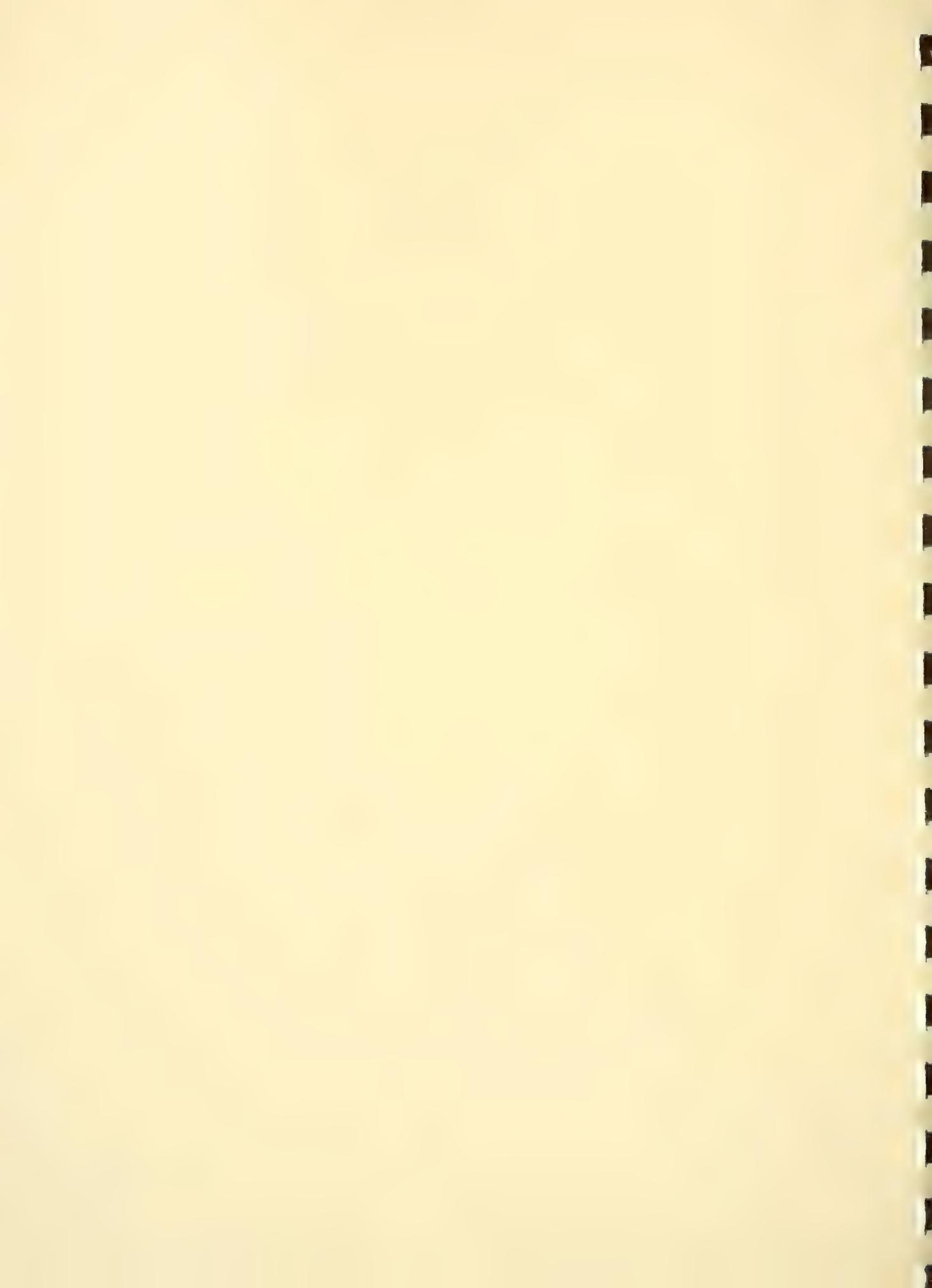
37. Claims processing performance standards management.

Claims Processing turn-around time goal is 7 to 10 days. The process is audited internally.

TOPIC SEVEN - Antifraud

39. Antifraud programs and education designed to enhance cost control.

Continuing education for claims personnel and legal staff to recognize potential fraud.



MT



March 4, 1994

Ms. Dorothy Bradley
Montana Health Care Authority
P. O. Box 200901
Helena, MT 59620-0901

NAIC #70319 260

RE: Cost Management Plans

- Dear Ms. Bradley:

We received your request for a response to your memo dated January 1, 1994.

Unfortunately, this memo appears to have been misdirected within our office and was just recently provided to the proper area. As you are aware, a significant amount of information has been requested and it will take time to prepare. For this reason, we need to request an extension to April 15, 1994.

We appreciate your patience and understanding and look forward to your granting the extension.

Sincerely,

A handwritten signature in black ink that reads "Christine Meehan".

Christine Meehan
Health Compliance

Enclosed
3/30 p.m.
Christine Meehan

**AREA THREE
UTILIZATION MANAGEMENT**

12. CASE MANAGEMENT

IDENTIFICATION MECHANISMS

1. CUSTOMER SERVICE BENEFIT CALLS - See attachment 12.1
2. PRECERT CALLS AND SCREENING - See attachment 12.2A/B
3. LARGE DOLLAR CLAIM IDENTIFICATION

ASSESSMENT

1. MONTHLY CASE REPORTS -- See attachment 12.3
2. YEARLY CASE MANAGEMENT SAVINGS REPORTS -- See attachment 12.4

APPEALS -- See Concurrent Review Section

#13. PRE-ADMISSION AND ADMISSION REVIEW

INDIVIDUAL BUSINESS

1. UTILIZATION REVIEW -- See ADMAR Manual - attachment 13.1
2. PRECERT INCLUDES BOTH INPATIENT AND OUTPATIENT SURGERY
3. APPEALS PROCESS -- See ADMAR Manual

GROUP BUSINESS

1. UTILIZATION REVIEW -- See HPR Services - attachment 13.2
2. PRECERT INCLUDES BOTH INPATIENT AND OUTPATIENT SURGERY
3. APPEALS PROCESS -- See HPR Services

#14. CONCURRENT REVIEW -- See Manuals # 13.1,2

#15. DISCHARGE PLANNING -- See Manuals # 13.1,2

#16. OUTPATIENT UTILIZATION REVIEW -- See Manuals # 13.1,2

#18. INTERNAL RETROSPECTIVE REVIEW -- See Manuals # 13.1,2

**AREA THREE
UTILIZATION MANAGEMENT**

12. CASE MANAGEMENT

IDENTIFICATION MECHANISMS

1. CUSTOMER SERVICE BENEFIT CALLS - See attachment 12.1
2. PRECERT CALLS AND SCREENING - See attachment 12.2A/B
3. LARGE DOLLAR CLAIM IDENTIFICATION

ASSESSMENT

1. MONTHLY CASE REPORTS -- See attachment 12.3
2. YEARLY CASE MANAGEMENT SAVINGS REPORTS -- See attachment 12.4

APPEALS -- See Concurrent Review Section

#13. PRE-ADMISSION AND ADMISSION REVIEW

INDIVIDUAL BUSINESS

1. UTILIZATION REVIEW -- See ADMAR Manual - attachment 13.1
2. PRECERT INCLUDES BOTH INPATIENT AND OUTPATIENT SURGERY
3. APPEALS PROCESS -- See ADMAR Manual

GROUP BUSINESS

1. UTILIZATION REVIEW -- See HPR Services - attachment 13.2
2. PRECERT INCLUDES BOTH INPATIENT AND OUTPATIENT SURGERY
3. APPEALS PROCESS -- See HPR Services

#14. CONCURRENT REVIEW -- See Manuals # 13.1,2

#15. DISCHARGE PLANNING -- See Manuals # 13.1,2

#16. OUTPATIENT UTILIZATION REVIEW -- See Manuals # 13.1,2

#18. INTERNAL RETROSPECTIVE REVIEW -- See Manuals # 13.1,2

AREA FOUR

ALTERNATIVE MECHANISMS FOR PAYMENTS TO PROVIDERS

#22. HOSPITAL PAYMENT

COMPETITIVE PRICING

1. ENCOURAGE USE OF PPO FACILITIES THROUGH INCENTIVES/DISINCENTIVES

2. PROSPECTIVE NEGOTIATIONS FOR DISCOUNTS

3. SILENT NETWORK FOR SAVINGS

4. RETROSPECTIVE NEGOTIATIONS FOR DISCOUNTS

CENTERS OF EXCELLENCE -- See attachment #22.1

UNBUNDLING

1. Individual Claims -- utilize HPR Code Review
see attachment #22.2

2. Group Claims -- utilize ERISCO Clinicalogical Review
see attachment #22.3

#23. PROFESSIONAL PAYMENT

1. Use of 80% and 90% of HIAA Data
2. Use of HPR Code Review and ERISCO Clinicalogical
3. All plans have deductible and copayments
4. PPO Claims are repriced based on contracted amounts

#24. OUTPATIENT HOSPITAL SERVICES

1. PPO Claims based on contracted amounts
2. Non-PPO claims based on resource data from Vendor
3. Rebundling programs used here also

#25. BULK PURCHASING

1. Case Management Vendors encourage Mail Order Pharmacy and DME from National Mail Order Vendors --
see Attachment 25.A
2. Plans have optional PCS Drug Cards

FOUNDING MEMBER COMPANIES

ETNA Life Insurance Company
VA
Alders Health Insurance
The Guardian
LIFE
al of Omaha Companies
nsylvania Blue Shield
e Travelers Companies

CORPORATE MEMBERS

ue Cross Blue Shield Association
ue Cross Blue Shield of Illinois
ue Cross Blue Shield of the National Capital Area
ue Cross Blue Shield of New Jersey
ue Cross Blue Shield of Virginia
ue Cross of California



NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

1255 Twenty-Third Street, NW
Washington, DC 20037-1174
Phone: 202/659-5955
Fax: 202/833-3636

Blue Shield of California
Delta Dental Plan of California
Empire Blue Cross Blue Shield
MassMutual
New York Life
Northwestern National Life
Phoenix Mutual
Principia Financial Group
State Mutual Companies
Time Insurance Company
US Life

PUBLIC SECTOR

Florida Medicaid Fraud Control Unit
National Association of Medicaid Fraud Control Units
US Dept. of Health & Human Services -
Office of Inspector General
US Department of Justice

GUIDELINES TO HEALTH CARE FRAUD

ADOPTED BY THE NHCAA BOARD OF GOVERNORS

NOVEMBER 19, 1991

Health care fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although the specific nature or degree of the criminal acts may vary from state to state.

The variety of fraudulent reimbursement and billing practices in the health care area is potentially infinite. The most common fraudulent acts include, but are not limited to:

1. Billing for services, procedures and/or supplies that were not provided.
2. The intentional misrepresentation of any of the following for purposes of manipulating the benefits payable:
 - a. The nature of services, procedures and/or supplies provided;
 - b. The dates on which the services and/or treatments were rendered;
 - c. The medical record of service and/or treatment provided;
 - d. The condition treated or diagnosis made;
 - e. The charges or reimbursement for services, procedures, and/or supplies provided;
 - f. The identity of the provider or the recipient of services, procedures and/or supplies.
3. The deliberate performance of unwarranted/non-medically necessary services for the purpose of financial gain.

1. Introduction.

Welcome to PINS -- the Provider Indexing Network System.

PINS is a national, on-line database--accessible for data input and retrieval by telephone modem--for use by member organizations of the National Health Care Anti-Fraud Association (NHCAA) as an aid in their investigations.

PINS represents the computerization of the information-sharing process conducted by NHCAA member organizations during the last several years. As such, its use is governed by the legal guidelines originally applied to that information sharing and those developed specifically for PINS. Specific legal guidelines to the system's use appear throughout this User Manual, while the broader legal considerations related to the sharing of investigative information are discussed under separate cover in a memorandum from NHCAA's General Counsel.

The PINS legal guidelines also dictate that non-governmental user organizations agree in writing (1) to adhere to those guidelines, and (2) to indemnify all other user organizations against their own misuse of PINS data. No organization may use PINS until it has submitted its written agreements to NHCAA Headquarters. NOTE: Special considerations apply to PINS use by public law-enforcement agencies and are described on Page 3-2 of this Manual. A failure to adhere to these guidelines may result in termination of that company's participation in PINS.

The PINS database is physically housed at NHCAA Headquarters in Washington, DC, where it operates under the supervision of a System Administrator. The System Administrator will (1) monitor and report periodically on various aspects of PINS use; (2) enter data on certain types of public-record fraud cases; and (3) be available to system users to answer questions and troubleshoot any usage problems.

You may contact the System Administrator (1) by leaving an "E-Mail" message on PINS, or (2) by calling NHCAA Headquarters at (202)659-5955.

Other, non-technical questions concerning PINS and its use may be directed to the NHCAA Executive Director and/or the NHCAA General Counsel.



TO: Montana Health Care Authority
FROM: Western Farm Bureau Life Insurance Company...
Larry Pease, Assistant Vice-President Claims and Health Service
RE: Cost Management Plans
Date: March 11, 1994

POINT 13. Pre-admission and admission review

Pre-certification is required for all in-patient hospitalization and for extensions beyond the initial pre-certification. Days of in-patient hospitalization which are not pre-certified are paid at a reduced percentage. Certification is accomplished through the insured's physician contacting HealthCare COMPARE, an independent cost management/utilization company.

POINT 5: Provider networks

A PPO network for in-patient and out-patient hospital care has been made available. It is not mandatory that a PPO facility be used. However, there is a cash incentive to the policyholder for such use. The PPO is through HealthCare AFFORDABLE. A copy of the Montana hospitals which are members of the network is enclosed. See EXHIBIT 1

POINT 3: Flexible benefit plans

A number of cost containment provisions have been incorporated into the policy. A copy of the provisions is enclosed in lieu of listing them here. See EXHIBIT 2

POINT 12: Case management

HealthCare COMPARE is used for case management of catastrophic cases. Case management when handled professionally has been found to be beneficial in maximum utilization of the benefit dollars.

POINT 37: Internal monitoring

Timeliness of claim processing is monitored on a weekly basis to assure that all claims are handled as received and within the established time limits. Quality assessment is an on-going process through random peer claim review.

POINT 33: Acceptance of standardized claims formats

Company produced claim forms are provided as a convenience. They are not required. Any claim form is acceptable which provides sufficient information to correctly process the claim.

POINT 35: Acceptance of common coding schemes

All coding schemes are acceptable. Typically the CPT and ICD-9 are the most commonly used and easiest to administer.

We hope this information will provide you with some assistance in your endeavor. If we can provide any additional information or further details on the attached, please let us know.

2. The deductible will not be applied if a covered person incurs covered medical expenses where: (a) an injury results from riding as a passenger in any vehicle required by state law to be licensed for operation on a public highway; and (b) we are given proof that the covered person was wearing a seat belt or similar safety restraint at the time of the accident, as evidenced by a police report.
3. **COMMON ACCIDENT** - If 2 or more covered persons are injured in the same accident, only one deductible amount will be applied to all covered medical expenses incurred during the same calendar year as a result of the accident. The covered medical expenses incurred by all covered persons injured in the accident will, if necessary, be combined for purposes of satisfying the "common accident deductible."

The Maximum Benefits described in Part E will apply to each covered person separately.

E. MAXIMUM BENEFITS

We will pay up to the Maximum Aggregate Benefit shown on page 3 for covered medical expenses of a covered person which are incurred while this policy is in force.

The Maximum Aggregate Benefit is subject to any other applicable limits stated in the policy. For example, benefits for private duty nursing will be limited to the Maximum Lifetime Benefit per Person for Private Duty Nursing shown on page 3.

F. EXTENSION OF BENEFITS

If a covered person is totally disabled, as defined, on the date this policy ends due to our refusal to renew the policy, we will provide coverage under the policy for an injury or sickness connected with the disability as long as the person remains totally and continuously disabled, but for no longer than to the earlier of:

1. the end of the calendar year; or
2. the date the Maximum Aggregate Benefit is incurred.

G. COST CONTAINMENT PROVISIONS

These provisions are designed to reduce the total cost of medical care received by a covered person because of an injury or sickness. Benefits payable under this Part G will apply toward the aggregate lifetime maximum explained in Part E. The deductible stated in Part D will also apply to

these benefits unless stated otherwise. Expenses covered by Parts B and G will be used to satisfy the deductible.

1. **HOSPITAL CONFINEMENT REVIEW REQUIREMENTS** - Hospital confinement review is required when a covered person is or is to be confined in a hospital.

Definitions

"Utilization Review Panel (Panel)" means us or the Panel named by us.

"Admission Information" means the following information which the attending physician must provide to the Panel before a period of confinement is approved:

- a. the diagnosis or reason for the confinement;
- b. any proposed treatment or surgical procedure; and
- c. the expected days of confinement.

"Medical Emergency" means a severe condition which:

- a. results in symptoms which occur suddenly and unexpectedly; and
- b. requires immediate physician's care to prevent death or serious impairment of the covered person's health.

Rules for Hospital Confinement Review

- a. **For a Nonemergency Admission** - The attending physician must notify and give admission information to the Utilization Review Panel (Panel) by phone at least seven days before the hospital admission. Within one day after the Panel receives the required information, the Panel will send written notice of any one period of confinement which is certified as medically necessary to: (a) you; (b) the physician; and (c) the hospital.

If the Panel does not receive the notice at least seven days before hospital admission, coverage will be provided as explained in the Effect on Benefits provision.

- b. **For an Emergency Admission** - If a covered person is hospital confined for treatment of an injury or as a result of a medical emergency, then the attending physician must notify and give admission information to the Panel by phone: (a) within 48 hours after a weekday admission; (b) within 72 hours after

a weekend admission; or (c) as soon as reasonably possible after that. On the same business day that the Panel received the required information, the Panel will (1) phone the physician and confirm any days of hospital confinement which are certified as medically necessary; and (2) send written notice to you, the physician and hospital to confirm any days of confinement which are certified as medically necessary.

c. For Continued Confinement - Before the approved period of confinement ends, the Panel will phone the attending physician to determine whether the covered person requires further hospital confinement. On the same business day, you, the physician and the hospital will be sent written notice to confirm any additional days of confinement which are certified as medically necessary.

d. For Weekend Admission - If a covered person is admitted to a hospital for treatment of an injury or sickness on a Friday or Saturday, the Panel will not certify the expenses as medically necessary unless:

- (a) the confinement is a result of a medical emergency;
- (b) a surgical operation is scheduled for the day or day after the date of admission; or
- (c) medical treatment requiring hospital confinement is scheduled for the day or the day after the date of admission.

Effect on Benefits

For expense incurred for days of hospital confinement which are certified by the Panel as medically necessary, benefits will be payable as stated in Part A.

For expense incurred for days of hospital confinement which are not certified as medically necessary, benefits will not exceed 65% of the expense incurred in excess of the Deductible for all covered medical expense if not done on an outpatient basis.

2. INPATIENT SURGERY BENEFIT LIMITATION - If a covered person undergoes any of the surgical procedures listed below while an inpatient in a hospital, then benefits will be paid at 65% of the covered expense incurred in excess of the Deductible during such hospital confinement.

The above limitation will not apply to a surgical procedure listed below when:

a. hospital confinement as an inpatient is medically necessary:

(1) because the covered person's medical condition will require prolonged post-operative observation by a nurse or other skilled medical staff;

(2) because of the covered person's anesthesia status; or

(3) because of technical problems shown by the covered person's admission notes or operative report; or

b. another surgical procedure which requires hospital confinement:

(1) will be performed at the same time; or

(2) may follow the first procedure (as when a prostatectomy may follow a prostate biopsy).

Surgical Procedures to be Performed on an Out-patient Basis

According to generally accepted medical practice, the following surgical procedures may be safely performed on an outpatient basis:

Arthroscopy (internal exam of joint)
Bronchoscopy (internal exam of lung), adult, with or without biopsy

Cataract removal

Cystourethroscopy (internal exam of urinary bladder and urethra)

Digestive tract endoscopy (internal exam of esophagus, stomach, colon or rectum)

Dilation and curettage of uterus (D&C)

Excision of pilonidal cyst, simple

Laparoscopy (internal exam of abdomen)

Laryngoscopy and tracheoscopy (internal exam of larynx and windpipe)

Morton's neuroma (of foot)

Myringotomy (puncture of membrane in ear), with or without insertion of tubes

Prostate biopsy

Reduction of nasal fracture, open or closed

Release of carpal tunnel (in wrist)

3. HOSPITAL PREADMISSION TESTING BENEFIT - When a covered person incurs expense for hospital preadmission testing, we will pay 100% of such expense. The Deductible does not apply.

The following limitations apply:

- a. The covered person must be admitted to the hospital as an inpatient within seven days of the preadmission testing for the same condition for which the test was performed. If not, benefits for these tests will be considered under Part A.
 - b. The preadmission tests are not duplicated on an inpatient basis. If a test is duplicated, benefits for the original and repeated test(s) will be considered under Part A.
 - c. Any preadmission test must be the kind that would be covered under Part A if hospital confined.
- 4. MANDATORY SECOND SURGICAL OPINION BENEFIT** - A second surgical opinion is mandatory when any surgical procedure listed below is to be performed on an inpatient basis. If the second opinion does not confirm the need for surgery, a third opinion is required. The second or third opinion must confirm that surgery is medically necessary before benefits will be paid under Part A. If the second or third opinion does not confirm that surgery is medically necessary, then benefits will not exceed 65% of all covered expense incurred during such hospital confinement for that surgical procedure.

We will pay 100% of the expense incurred for a second opinion on the need for surgery (including x-ray and laboratory services). The Deductible will not apply.

If the second surgical opinion does not confirm that the proposed surgery is medically advisable, we will pay benefits in the same manner for a third opinion.

Conditions

Benefits will be payable only if:

- a. the opinion is given by a specialist who:
 - (1) is certified by the American Board of Medical Specialties in a field related to the proposed surgery;
 - (2) is independent of the physician who first advised the surgery; and

(3) does not perform the surgery for the covered person;

- b. the specialist makes a personal exam of the covered person; and
- c. the specialist sends us a written report.

These mandatory second surgical limitations will not apply if the covered person undergoes a surgical procedure listed below:

- a. on an outpatient basis;
- b. after obtaining a second or third opinion which confirms the need for surgery; or
- c. as a result of medical emergency.

Surgical Procedures for Which a Second Surgical Opinion is Mandatory

Breast surgery, augmentation or reduction

Bunionectomy (foot surgery)

Cholesystectomy (removal of gallbladder)

Coronary artery bypass surgery

Hemorrhoidectomy, internal or external

Hernia repair, inguinal or hiatal

Hysterectomy (removal of uterus)

Laminectomy (back surgery)

Ligation and/or stripping of varicose veins in legs

Meniscectomy (knee surgery)

Septoplasty and/or submucous resection (nose surgery)

Tonsillectomy and/or adenoidectomy (removal of tonsils or adenoids)

Transurethral prostatectomy (removal of prostate)

H. EXCLUSIONS, REDUCTIONS AND MEDICAL EXPENSES NOT COVERED

No payment, and no allowance toward any deductible amount, will be made for expenses incurred for any of the following:

1. pre-existing conditions - Any injury, sickness or abnormal physical condition for which, within the 5 years before the date a person is covered under this policy:
 - a. symptoms existed that would have caused an ordinarily prudent person to seek diagnosis, care or treatment; or
 - b. medical advice or treatment was recommended by, or received from, a physician.

May 20, 1994

Dorothy Bradley
Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

Re: Cost Management Plans

Dear Ms. Bradley:

This letter is in response to Senate Bill 285 that asked for "standards and guidelines" from insurers to assist the Authority in the preparation of cost management plans. Because of the small size of our company, we do not have available staff as do larger concerns in the area of cost management. We therefore contract with outside advisors and experts to provide services for us in areas where we do not have the staff to provide for ourselves. In this we have been successful and are involved in several programs that help manage costs.

To begin, we do not insure a significant number of residents in Montana. We currently insure only petroleum marketers that total approximately 95 groups which translates into 1983 lives including dependents. Annual premium in 1992 was \$828,767.

Our cost management is based in several areas:

1. We write insurance for the petroleum marketing industry. We know this industry well having been involved with its health coverage since 1974.
2. We utilize the services of USA-Healthnet which is a national PPO network company contracting with physicians and hospitals for discounts.
3. We utilize the services of Intracorp which is a pre-authorization company and a large case management company for long-term care patients.
4. We encourage each insured to help the company control claim costs as much as possible.
 - a. Our plans have a deductible and co-pay provision which encourages everyone to be a better consumer of health care.
 - b. If the insured will use the cost saving PPO network, their co-pay is 90% rather than 80%.
 - c. Insured individuals who are able to find and correct errors in hospital bills are rewarded with a 50% return of the savings to a maximum of \$200.

- d. We contract with The Hope Institute which provides educational material on preventative care and advise to our insured people under in the form of a WMIC Newsletter and a variety of health care brochures.
5. Our processors are trained to watch for fraud and abusive use of the plans.
 6. Large hospital claims are audited by a national service particularly if there is any suspicion that there could be errors involved. Hospitals (non-PPO) that have good audit experience are asked to discount claims for a non-audit and quick pay.
 7. Any unusual claims that appear questionable or difficult are referred to the Medical Review Institute which is a group of physicians that review claims for a large number of insurance companies.
 8. We include in our contract a provision for arbitration on disputed claims in order to avoid costly litigation.
 9. We control administrative costs by processing claims within our office rather than using the services of a third party administrator. In addition the officers and directors serve without pay with the exception of a board meeting attendance fee. We do not have commissioned agents and do not sell to the general public.

COST MANAGEMENT PLAN NARRATIVE

AREA ONE: Integrated Systems for Health Care Delivery

Our company is too small to have a strong integrated system for health care delivery. We compensate by contracting with The Hope Institute which provides educational material to our insured people in the form of a WMIC Newsletter and health care brochures. In addition we contract with a national provider network which we feel promotes cost-effectiveness.

AREA TWO: Quality Improvement and Assessment

Again, we do not have staff to work on an extensive quality improvement and assessment program in the classic sense. We rely on our PPO network to provide the oversight necessary in this area.

AREA THREE: Utilization Management

We contract with Intracorp, a national company which specializes in utilization management. They provide pre-admission, length-of-stay, large case management and utilization review services. This is a valuable benefit that we could not provide ourselves because of the limited size of our own company.

We have had success in encouraging each insured to help the company control their own claim costs. Our plans have deductible options and a co-pay provision. If the PPO network is used then the co-pay is 90% rather than 80%. Also individuals that are able to correct hospital billings, are rewarded by receiving a check for 50% of the savings to a maximum of \$200.

AREA FOUR: Alternative Payment Mechanisms to Providers

We have contracted with USAHealthnet which is a national PPO network which contracts with providers and negotiates discounts for a large number of insurance companies throughout the country. The savings is helpful in controlling costs.

We are supporting "episodes-of-care" pricing in order to better manage costs in the future.

AREA FIVE: Third Party Liability/Coordination of Benefits

Our claims processors are well trained to investigate for responsible third party entities. We are involved in subrogation where possible, with other insurance carriers to avoid double payment and to initiate coordination of benefits.

AREA SIX: Administrative Methods

Even though our company is very small, we are constantly looking for ways to save money on administration. We are presently at 6.1% overhead which includes claims, billing and management. We are very proud of this low figure. We do not use agents because we do not sell to the general public which saves our company approximately 10% over other companies. We use the services of Medicode which provides a relative value scale which compares provider charges with the reasonable and customary charges in common use in the area.

We accept all the forms that are in common use within the industry. The standardization of forms in connection with the establishment of procedure protocols would be most helpful in lowering paperwork cost.

We are looking at Electronic Claims Transfer (ETC or WEDI) to further enhance efficient claims processing. In order for this to work there will need to be additional standardization of computer systems that both send and receive claim information.

AREA SEVEN: Anti-Fraud Efforts

We are do not have a large enough staff to concentrate on fraudulent claims. However, the processors are trained to investigate any suspicious claims and to identify potential fraud.

Regarding the Health Insurer Data Sheet which is enclosed, we were not able to generate all of the 1992 figures requested outside of the total written premiums and total claims incurred. The contracts, number of lives and administrative cost are all current 1994 figures. The breakdown of premiums and claims is estimated.

If there is any additional information that would be helpful from our company, please let me know.

Yours sincerely,


Gerald Tedrow
President



P O BOX 3160 • OMAHA, NE 68103-0160 • (402) 496-8000 • FAX: (402) 496-8040

March 23, 1994

THE HEALTH INSURER COST MANAGEMENT PLANS
MONTANA HEALTH CARE AUTHORITY
CAPITOL STATION
HELENA MT 59620

To Whom It May Concern:

We appreciate the opportunity to comply with your request, per Senate Bill 285, Section 20.

As you can see, from the Health Insurer data sheet, World Insurance has limited policies in the state of Montana. The two policies that were issued are Individual Comprehensive Major Medical Policies. World Insurance has released the Health Select Series, which contains more cost management provisions, that are not outlined in this document. The reason being that this series was not filed for release in the state of Montana.

We hope that this document will aid the Authority in creating the planning documents and cost containment plans. If further clarification is needed, please call me at 402-496-8118.

Sincerely,

A handwritten signature in cursive ink that reads "Tyler A. Blaser".

Tyler A. Blaser
Claim Supervisor

TAB:pm75

I. Integrated Systems for Health Care Delivery Strategies:

1. Base policy contains coverage for a routine physical exam every 24 months.
2. All of our non-smokers are issued with standard rates, while smokers are issued with substandard rates. In efforts to lower the rate increases on our A3695 policies, the policyholders were given an option to add ReviewPLUS to their policy. ReviewPLUS is a preadmission screening program that helps the insureds use the health care system in a more informed way.
3. As mentioned above, ReviewPLUS makes sure that the treatment or surgery is the most appropriate for the insured. The best care ensures appropriate treatment at appropriate costs-not only does HRM look at appropriate care but they also notify us of potential case management files.
Our A3695 policy waives the deductible for any surgery performed on an outpatient basis thus discouraging institutionalization.
Our associates have been trained to identify catastrophic diagnosis', at this point we contract with a case manager who oversees the case and attempts to conserve policy benefits through early dismissal and negotiated home services.
4. Nothing in place.
5. Our case management firms provide a service called price shopping.
Through there various contracts with providers they can obtain the lowest possible price on durable medical equipment, medical supplies, prescription drugs, and other services.
6. None at this time.

II. Quality Improvement and Assessment

7. We have contracted with America's Health Plan which is known as a Cooperating Provider Network (CPN), the CPN is comprised of hospital, physician, and other medical providers, for access by World Insurance on a "Silent" basis. Each selected provider is reviewed within an evaluation process which includes:
 - Provider Accreditation, Certification, and Licensure
 - Quality of Care
 - Availability and Range of Services
 - Utilization Controls
 - Financial Status

In order to be a participating provider the hospitals must have the following programs in operation:

- Quality Assurance Program
 - Medical/Utilization Review Program
 - Professional (Physician) Credentialing Program
 - Professional Credentialing Program for non-physician prof.
 - Infectious Disease Control Program.
8. None at this time.
 9. None at this time.
 10. None at this time.

III. Utilization Management

11. Our AHP participating providers are profiled and are held accountable for

for meeting utilization standards.

12. Hines and Associates is a private company through which we contract for case management services. Hines has come in-house to hold training for our claims associates. This training has allowed them to identify those cases that need case management involvement. Hines does an outstanding job in getting the best possible care at the lowest possible price. Hines evaluates and assesses the cases as often as you would like, should they get conflicting information from the provider they will do an onsite evaluation and then make a recommendation. Should this not be suitable to the provider we have a Claim Review committee that has legal representation as well as a medical opinion, in addition to our in-house medical director.
13. On those policies that require pre-certification all in-patient stays need to be reviewed as well as out-patient surgeries and diagnostic procedures. The following are instances where the policyholder must call ReviewPlus:
 - A. Non-emergency Hospitalization (10 calendar days before admission)
 - B. Emergency Hospitalization (as soon as your admitted, but no later than 24 hours, or the next business day, after your admission)
 - C. Maternity (as soon as your doctor confirms pregnancy, but no later than six months before the expected delivery date).

World and Health Risk Management (HRM) have established a list of surgical codes that require precertification. Once the provider has placed the call, the case is referred to a ReviewPlus professional who specializes in the particular medical condition. In assessing the care, the reviewer may contact the health care provider to gather additional information. This information helps ReviewPlus determine if the diagnosis and proposed treatment plan, setting and length of stay are medically appropriate for the insured. Because ReviewPlus physicians and nurses use the same nationally accepted medical guidelines that most doctors use, it is more than likely that the proposed treatment is medically appropriate, and the insured will be able to proceed as planned. However sometimes further review is necessary. When that happens, a ReviewPlus physician will consult with the insured's physician and evaluate the need for hospitalization or surgery. When reviewing the case, they will consider the unique situation which includes the insured's past medical history and current state of health.

14. Concurrent reviews are also conducted through HRM. Should additional days be required, the hospital's UR department should phone HRM and get those days approved.
15. Discharge planning is coordinated through our case managers.
16. All outpatient surgical/diagnostic codes need to be pre-certified through HRM.
17. Our claim system asks the associate to select/match the billed amount with the care that was pre-certified. Should there be a discrepancy the claim personnel will decide to pend for additional information, reject the care not pre-certified, or subtract a penalty from the benefits.

We pend all Hospital bills over \$5000 to HCX who makes a determination

as to whether the bill is appropriate or if an audit should be conducted. If the bill is appropriate they will then try to negotiate a discount.

We have also contracted with Health Payment Review (HPR), they provide us with a product called Code Review. This product rebundles unbundled claims, detects upcoding, or code creep, flags potential coding errors, and implements a variety of World Insurances options to support decisions specific to our payment practices or benefit design, such as cosmetic surgery, assistant surgeons and office visits. Code review also has provider reports that can be generated. These reports identify the frequency that certain providers are inaccurately billing us.

18. Should claim personnel or insureds, question any of our cost containment methods, World insurance does have an in-house medical director that can review such cases.
19. None at this time.
20. We receive monthly reports from our PPOs, that contain all relevant utilization statistics. In order to participate in the network providers need to meet all standards set forth in the contract. Providers contracts are reviewed on a regular basis.
21. None at this time.

IV. Alternative Mechanisms for Payment to Providers

22. Silent PPO arrangement is in place as well as prompt payment negotiations.
23. None at this time.
24. None at this time.
25. Case management company has nation-wide contracts with providers that we benefit from.
26. None at this time.
27. None at this time.

V. Third Party Liability/Coordination of Benefits Strategies

28. None at this time.
29. None at this time.
30. Calculation is done on an individual case basis. Coordination of benefits is only pursued if it is cost effective.
31. Our policy contains a variable deduct provision. This provision states that we use the primary payors amount as our deductible and reimburse the remainder of the charges at 100 percent. Most of this information is obtained over the phone so that timely claims processing can occur.
32. We execute our right of subrogation as well as any liens.

VI. Administrative Methods

33. We accept all standardized forms of billing in addition to super billings and receipts sent in from insureds. Should we need additional information from the providers we will place a phone call at the time of data entry.
34. None at this time.
35. We accept all common coding schemes except NDCs, DSM III and revenue center codes.
36. We are currently researching the various avenues in which to implement

- EDI. Our internal deadline is December of 94.
37. Part of our quality mission is to continually improve and measure our progress. By doing occasional surveys with our insureds and by also logging all grievances we can identify the areas that need refinement. Our weekly statistics for the claims department measure all aspects of our processing, ie timeliness, Quality, Accuracy, Pricing
 38. We have established procedures for our personnel that have met the quality control limits. In addition, we continue to automate our claim system (WICAS) in efforts to reduce costs.

VII. Anti-Fraud

39. World Insurance is a member of the North Eastern Anti-Fraud Association. This is an organization that meets monthly and primarily focuses on education as well as how to execute investigations. World has also begun its own fraud unit, Special Investigative Unit (SIU), which consists of claims personnel, legal counsel, and our medical director. They are responsible for all in-house training as well as identifying cases and executing investigations.
Included with our explanation of benefits statement to the insured is a stuffer that informs the insured to review their explanation and notify us of any incorrect provider billings.
40. None at this time.

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